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THE MOTHER OF THE ADDICT*

BY PERCY MASON, M.D.

The personality of the mother of the adolescent and young adult drug addict has been a subject of considerable interest to the writer in some five years of contact with addiction, partly in private practice, partly through association with Riverside Hospital in New York City. Even though the addict himself is the patient and the primary object of investigation, his environment necessarily impinges upon the investigator. After a while, certain factors become so repetitious and so constant as to command special attention. Every patient, of course, has had a father and a mother, and both of them—present or absent—play a certain role in his life. The father of the addicts whom the writer has studied is usually either physically absent through death, separation, or work away from home; or he represents such a shadowy background figure, that little can be learned about him. The mother, on the contrary, is the "boss," and is always present—if not in person—exerting her influence upon the patient even when removed from him physically. To the addicts whom the writer has seen, the mother was always the preferred and the important parent.

Review of the Literature

The literature on addiction is not very extensive, and clinical reports of cases are few. Savitt[1] reports a successfully analyzed case, where the mother was very much the dominant figure in the family. She was a busy and successful businesswoman, who had weaned the patient abruptly after a few months; he later received more affection from a maid than from his mother.

A vivid and extensive description of an ambivalent relation between an addict and his mother is given by Gerard and Kornetsky.[2] The regressive, manipulative, and seductive features of their relationship are minutely reported. The same authors, in an earlier publication,[3] found that the mothers of addicts were "excessively controlling and strict (40 per cent); excessively indulgent, non-disciplining (48 per cent); seductive (24 per cent)," all qualities which the present writer's composite clinical picture clearly exhibits. On the other hand, Zimmering et al.[4,5] did not

*Read in greater part at the divisional meeting of the American Psychiatric Association, New York City, November 1957.

feel that there was anything destructive about the "close empathetic" relation of mother and addict son.

Mannheim's patient[6] was an unwanted baby, born in spite of attempts to abort. "Nurses and governesses who became friendly with the child were usually dismissed." The short period of breast-feeding was extremely stormy. There was a long succession of severe gastro-intestinal disturbances, and eventually a wet-nurse had to be engaged as a life-saving measure. She was summarily dismissed as soon as the child's health improved. The mother's interference was prominent throughout the life of this patient, whose problem was addiction to drugs and food, as well as homosexuality.

Winkelstein's patient[7] had similar early experiences. There was a stormy three-week period of breast-feeding, following which he was taken care of by a kindly maid, the only person who, in his recollections, had been good to him. The mother herself was not interviewed by Winkelstein, but, as seen through the patient's eyes, she appeared hostile and "controlling."

Rioux[8] reports on a case where the patient remained constantly with his domineering mother until he was 10. He eventually developed a reaction formation of inability to accept discipline, and avoidance of all maternal care.

Clinical Material

When one is dealing with adolescents or young adults, the process of therapy almost always involves initial contact with at least one of the parents. The writer has never seen the father of one of these young addict patients in his office; and in the hospital the mothers were the contacts in an overwhelming majority of the cases.

Some time ago, the middle-aged mother of a 24-year-old addict appeared in the writer's office. She stated that her son, a known drug addict, had voluntarily signed himself into Bellevue Hospital, and now after four weeks was perfectly willing to allow Bellevue to transfer him to a state hospital, since this seemed to be the only way to obtain treatment for his condition. The mother requested help in signing her son out of Bellevue, because "after all he does not belong there; it would be a terrible shame on my family if anybody thought he was crazy." All attempts to explain to her that her son was taking the only course available to him

in trying to break the drug habit were of no avail. She left the office angrily stating, "I am the mother, I am the only one who knows what is good for him."

Several patients did appear at the office, requesting help with their addictions. After discussion of the situation with a patient, the mother would be seen separately. Her only concern would be, "Did he take a shot today? He always lies to me." Discussions of the problems of long-range treatment fell upon completely deaf ears, and the conversations were at times amusing, and at times irritating, since doctor and mother were obviously talking about different things. It goes without saying that these mothers were not interested in any treatment for their children.

In the hospital, one has the opportunity to read some of the letters these mothers write to their sons. Keeping in mind that the majority of the hospital patients are between 18 and 20 years of age, one is struck by the numerous expressions of endearment: "dearest," "darling" and "sweetheart." The letters contain many statements like "I love you very much," and "All my love to my only sweetheart," and they often end with a line of X's, denoting "love and kisses." Many of them are signed, "Mommy." This infantilization goes to the point where one mother wrote to her almost-21-year-old son: "Wish you were here for Easter so I could buy you a bunny rabbit." Similar expressions have been used in connection with birthdays, and Christmas. Fort[9] reports inquiries by mothers of patients over 25 years of age, "How is my baby?"

On the other hand, very strong hostile feelings are openly expressed in such letters. There is a whole gamut of expressions ranging from, "Drop dead," "Why don't you kill yourself?" to a reproachful, "Why do you do this to me?" This last question applies, not only to the addiction itself, but to many episodes which cause the mother annoyance, inconvenience, or worry.

One of the most interesting letters is one in which the mother's ambivalence is written all over the pages. She wrote from her vacation, "I am going to be home next week, and if I am allowed I would be over to see you almost every day (smile)." And then, as the *coup de grace,* she added, in describing her constant thinking of her son (Billy), "Everybody in the street is Billy, and all dogs are mad dogs." This letter, too ends with the usual, "I love you very much."

At the hospital, in daily contacts, the mother is not the most helpful person to deal with. It is very difficult to get some of these mothers to come to the hospital to give the information needed for a proper work-up of a patient. When a mother does comply and come, information is frequently distorted—or it is withheld, sometimes on the excuse of memory lapses, sometimes because of hostile feelings against the agency. Many times, this attitude amounts to actual collusion between mother and son. One mother covers up her son's escape from a reformatory, "He wasn't anxious to go back." Another declares in the face of overwhelming evidence of her son's involvement in a burglary, "He is such a wonderful kid—he wouldn't lie."

The mother's possessiveness, her inability to grant her son independence, may be manifested by her numerous attempts to interfere with hospitalization and treatment—to the point of forcing him to leave the hospital. Raising questions, real or imaginary, of her own or some relative's health, or of financial difficulties, she kindles the son's anxiety and guilt feelings, in letter after letter, to the point where—one way or another—he has to leave the hospital and rejoin her.

Possessiveness is also shown through the numerous phone calls, inquiries, requests for special privileges. But many a time this is done with the intent to maneuver and deceive. The hospital has received requests on many occasions for an emergency pass for a patient, on the basis of the death or serious illness of a relative. One such case started with a telegram announcing a grandfather's death. That was corrected a bit later by a phone call saying that the grandfather wasn't really dead but pretty sick. Eventually the grandfather wasn't even sick; but the mother simply wanted her son home. This particular case ended on a relatively harmless note; but another one, unfortunately, ended with the patient dying of an overdose of heroin, while on an emergency pass obtained under similarly untruthful circumstances by the mother.

Sometimes preoccupations about a son's welfare—which mean, "I am the only one who can take care of him"—have slightly grotesque features. The mother of an adolescent, 50 pounds overweight, called almost daily to inquire whether her son got enough to eat, and insisted that only the starchy foods of her national background could be satisfactory to him. The son, too, said he wanted his mother's cooking. Stuffing her son this way and making

him the butt of ridicule in the neighborhood was one of this mother's ways to hold him in bondage, and his professed reason for resorting to drugs.

Instances of smuggling money, clothes and so on into the hospital are rather common, though there is no need for smuggling at all, since there are perfectly legitimate ways of making such things available to patients. (This availability does not apply to liquor, which well-meaning parents have also tried to bring in.) There are many attempts to circumvent hospital regulations pertaining to visitors who are restricted to parents and spouses. One mother created a scene by permitting herself to be caught smuggling in a forbidden item to her son, so as to allow him, in the midst of the commotion thus created, to talk to his girlfriend, who ordinarily would not be permitted to visit.

But such attitudes toward the hospital may be understandable to some extent, it may be said, since hospitalization involves restriction and confinement. The mother's "helpfulness," however, involves much more than this; it involves in many instances supplying money to buy drugs. This does not apply only to the time when the patient is allegedly in the throes of withdrawal symptoms and parental feelings are stirred to the extreme. The reasons for supplying money are numerous and all lame, like, "I don't want him to steal to get money for drugs," or, "He wanted to buy a shirt, I didn't think it was for drugs." It has been observed over and over again that the mother gives money for different purchases, for carfare, or an employment agency fee, in exactly the amount needed for a "shot." Many times, a youngster is almost forced by the mother to "Take this, have some fun," ostensibly referring to a party, a dance, or movies. The same mother who does this complains that she can never trust her son with anything, that he cannot be left alone for a minute, and so on. But any implication of complicity, duplicity or sheer blindness would be rejected as slanderous.

Many times marriage is thought of as a panacea—as it would be in any other constellation. "I'll be happy when he gets married" means either, "as long as he is out of my house," or, "Let somebody else take over." The situation becomes a bit ludicrous, the mother encouraging dates, and urging the son to go out. But lo and behold, as soon as a likely prospect appears on the scene, the wind blows in a different direction. Veiled and open criticism,

veiled and open hostility come to the fore. Depending upon the openness of the conflict within the mother, the attack is either against the intruder, "What do you see in her?" or against the son, "Who would want to marry an addict?" When, after overcoming such odds, the marriage comes to pass, the mother does everything to destroy it and to regain possession of the son. Innuendoes, accusations, subtle rumor campaigns worthy of a Shakespearian villain, are wedged between the couple. Many a time, the mother succeeds, since these marriages are built on shaky foundations on both sides. The marriage flounders, and the son returns to mother.

There is more to this than just a question of economics—in cases where the establishment of an independent home would be a difficult undertaking in a poor social setting. Patients from a comfortable economic background behave the same way. Savitt's patient, coming from a well-to-do family, slept in his parents' bedroom at the age of 19; and, later, during the father's absences on business trips, the mother again invited her son to share the bedroom. Returning to the lower economic strata, however, it is not uncommon for the children to share their parents' room and bed. But in the writers' patients this occurred in the late teens, and even upon their return from failing marital adventures. No instance of overt incest is known among the writer's patients, but the bearing of this background on marital difficulties is obvious.

Pre-Addiction Patterns

Among the laity there is a marked tendency to ascribe many of the behavioral patterns mentioned to family social and economic background. Another child in a poor family may represent only more hardship, less space, less food and clothing in an already marginal way of life. Many children are unwanted and are not exactly received as bundles from heaven. Attitudes of rejection, hostility and bitterness do not stem merely from the disappointments, worries and tragedies that the presence of an addict within a family may bring. An attempt was made to delve into the childhood relations of these patients, into eras of their lives well predating the addiction. A study of early feeding patterns among these patients showed the following: Among 65 patients (a random sample) interviewed at the hospital (52 males and 13 females) a total of 40 (31 males and nine females) had been breast-fed for

varying times, rarely exceeding three months. Weaning, in many instances, was accomplished abruptly, because of illness, the necessity of the mother's going to work, or the mother's reluctance to continue feeding the child. But again Savitt,[1] Mannheim,[6] and Winkelstein[7] provide similar data from a higher social and economic background. The siblings of the writer's patients fared worse: Only 32 of them (24 males and eight females) were breast-fed by their mothers. The patients' children will fare even worse: Only 25 of the patients interviewed (17 males and eight females) thought that their children should be breast-fed. These data, the writer believes, indicate a trend away from breast-feeding, but not because it is old-fashioned. (This factor was emphasized only by male patients of Puerto Rican origin.) The writer thinks that it reflects the patients' reaction to the hostile, reluctant, ungracious way they were treated by their own mothers. There were three patients (one male and two females) who, although not breast-fed themselves, expressed the opinion that their children should have the benefit of breast-feeding, thus, maybe, obtaining, through identification with their children, the gratification that they themselves missed.

The same 65 patients were asked to state their personal preferences between the two parental figures, as well as their impressions as to the preferred parent's own preference for themselves or for siblings. Of the whole 65 patients, only three females and one male preferred the father; all the others favored the mother. (The three females who preferred the father deserve some comment: One was an extremely unattractive prostitute; one had marked guilt feelings about having been the cause of her father's accidental death; the third had an overtly psychotic mother.)

In 24 instances, in this group, affection was not returned by the preferred mother. In five cases, however, the patient was almost apologetic about being the favorite. He was either the "baby" of the family, or an only child. Naturally, these expressions of opinion have been accepted cautiously, as not necessarily denoting the true state of affairs. At the same time though, one must keep in mind the fact that these patients have created such beloved and loving images as part of their dependency and security operations, because they probably could not accept the real emotions their world is permeated by.

Treatment of Mothers

Following good established psychiatric practice, attempts have been made to influence these patients in their home environments through treatment of their mothers. Only one or two of the mothers in the higher income brackets have accepted individual psychotherapy. The rest have either refused referral outright, or have followed it up in a most reluctant and perfunctory manner, finally dropping contact completely. The hospital has tried to involve these mothers in some kind of relation: membership in a parent-staff organization, or participation in group therapy. The parent-staff organization has an educational and social club atmosphere; out of more than 1,000 parents, only 30 or 40 appear at any one of the monthly meetings; and the same person rarely attends more than three meetings. At the group therapy sessions, attendance is also poor and the turnover great. Usually the mothers become anxious as soon as their personal problems come to the fore, following an innocuous discussion of the hospital and its function. Guilt over their hostility is probably the main factor driving them away from the group, and the presence of other mothers in exactly the same position is not sufficiently supporting.

A great deal has been written on the influence of paternal pathology upon children and upon the treatment process. Fabian and Donohue[10] discuss the role of the depressed mother in such a context. Pinsky[11] describes parents of disturbed youngsters who are concerned with themselves and their status rather than with their children's growth and independence. Johnson[12] has stated in numerous publications that the child acts out the repressed, antisocial impulses of the parent, who gives stimulation and tacit approval to the acting out. In discussing attempts to treat such parents and children, certain parental characteristics favorable to treatment are mentioned by Bernstein,[13] but it is obvious that few of the mothers of the addicts discussed here could satisfy such criteria. It is not surprising then that attempts at treatment have been generally uneconomical and time-consuming, and that the results have been disappointing. Yet, making a very broad generalization, one would be inclined to say that even such half-hearted and short-lived co-operation as has been obtained seems to have made the treatment process a bit more favorable.

Comment

This paper has been an effort to depict the mother of the drug addict. What conclusions may be drawn from descriptions of persons and reports of events which repeat themselves with astounding regularity and consistency? What is the composite picture of the mother of a young drug addict? It seems to the writer that such mothers are known to every psychiatrist. They are the controlling, overpowering, overprotective, guilt-ridden and unhappy women, who generally have profoundly hostile and aggressive feelings toward their children, but at the same time are unable to separate from them and grant them their independence—which would be a good thing for all concerned. The adjectives to describe them are numerous: narcissistic, inconsistent, rejecting, teasing, seductive, controlling, manipulating, and so on. What is the reason for the behavior of such a mother toward her child? The elements of envy, retaliation, and infantile fantasies of omnipotence are present.

An additional, and persuasive, concept has been advanced by Bromberg.[14] It is his contention that masochistic trends (and they are prominently displayed by the addict) are particularly strong in the child whose mother identifies him with one of her own parents toward whom she had a great deal of ambivalence, with a preponderance of hostile feelings. This is a very interesting hypothesis, although only extensive studies of three-generation groups could eventually substantiate it. The difficulty of such an undertaking is obvious. In the present series of patients, there was rather casual contact with one mother who had no difficulty in expressing her anger and hostility toward her addict son. She then continued to say that in addition to her troubles with the patient she also had to take care of her widowed mother, crippled by many ailments of old age: "I had to support her for the last 20 years, but what can I do—I can't kill her off, can I?"

One could easily voice the objection that not every such mother has an addict among her children; and an interesting discussion of the entire question of choice of symptoms might follow. The writer, however, believes that the type of mother described in this paper is an important factor in the son's addiction. She is encountered with such regularity and consistency as to preclude coincidence and to make her assume causal, although not exclusive, importance. That such a mother has a profoundly disturbing in-

fluence upon her children is well known: In the Riverside Hospital population, there are many families where several of the children are known addicts and the others almost always have severe psychological problems. In other words, not every such mother has an addict for a child, but a great many addicts have such mothers.

These mothers, because of their own problems, stimulate aggressive and sexual drives in their children and then proceed, frequently in a sanctimonious manner, to deny and disapprove of them. There is a marked disparity between what such women say and what they do; and they are apparently not aware of the damaging effect of such duplicity—which, as far as the patients are concerned, amounts to approval of their super-ego defects. The need to expiate guilt feelings related to early oral deprivations and childhood rejections leads these mothers to "protect" their offspring. They work so hard at it that they eventually feel overburdened, and blame the objects of their attention for overwork and a hard life; their negative attitudes turn this protection into controlling and domineering castrating-behavior.

This wavering back and forth between promise and fulfilment, on the one hand, and denial and punishment on the other, has, in the writer's opinion, a very definite place in the formation of a personality accustomed to accept pain and failure as an integral part of the promise of love. Such an extremely masochistic personality is represented by the addict, and the role of his mother in the formation of his masochistic traits is clear.

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FEAR IN ELECTRIC CONVULSIVE THERAPY, AND ITS ALLEVIATION THROUGH MUSIC*

BY LEO SHATIN, Ph.D., LEON W. LUSSIER, Ph.D., AND WALLACE KOTTER

Introduction

Music has been employed with electric convulsive therapy by a number of investigators in attempts to alleviate psychiatric patients' fear of treatment, and to influence the patients' reactions during the post-treatment recovery phase.

The present investigation was designed to test the hypothesis that music played to patients during the waiting period before electric shock treatment, serves to moderate fear during the waiting period. It was designed further to establish whether such moderation, if it occurs, is carried over to a postshock time much later in the day. The degrees of fear experienced under three experimental conditions were compared: silence, slow tempo popular music, and fast tempo popular music.

Fong[1] described the use of band music during and after electric shock therapy and stated that a gratifying response was obtained. The patients' resistiveness and inaccessibility to treatment were considerably reduced. Music for relaxation appealed to the depressed patients—soft, soothing, semi-classical pieces. Lively swing-type music was more attractive to the disturbed, catatonic schizophrenic patients.

A project undertaken in a mental hospital about 10 years ago[2, 3] attempted to ascertain whether the controlled use of music could augment the benefits of electric convulsive therapy. The duration of the project was 13 weeks. A portable record-player was used, with specially selected records played to patients before and after the treatments. The music was light and cheerful during the waiting period (before). It was quiet and soothing in the recovery period (after), "to calm and reassure the patients." This was followed by cheerful, mildly stimulating music, but never overstimulating, since the physicians wanted the patients to continue in a restful state for the remainder of the treatment day. Selections with sudden accents or varying dynamics were avoided. Although the original study plan had envisioned a controlled experiment,[3]

*From the Veterans Administration Hospital, and from Albany Medical College, Albany, N. Y.; and from the Hospitalized Veterans Service of the Musicians Emergency Fund, Inc., New York, N. Y.

the patients were so immediately and unanimously responsive to the music that it was integrated into the treatment program at once. The very first time that music was absent from treatment the patients became restless and noisy. It was then decided that music should not be omitted at any time thereafter. All but two of the 36 patients treated had a decided preference for having music. None found it disturbing. The author concluded that the proper use of music before and after electric shock could help to augment the effects of the treatment and would allay the patients' fear of treatment. Music had a calming and encouraging influence.

Price, Mountney, and Knouss[4] described a program of music employed to accompany ECT at Sheppard and Enoch Pratt Hospital since 1948. Music of three different types was played, corresponding to the three phases of treatment: the preparation, the return of consciousness, and the after-period, which included a half-hour of bed rest in the recovery area. During the preparatory or waiting period, music of a "peaceful" type was played to create a reassuring atmosphere. It was serious but not depressing. It was melodic, and selected to meet the mood of the patient; for example, Grieg's *Morning Mood* and Hayden's *Symphony* 99, second movement. Dissonant, depressing, and sentimental music was avoided. During the awakening period, music was intended to elicit pleasure. It was more melodic and more sentimental, but still without strong rhythm, for example popular American waltzes, *Holiday for Strings, Missouri Waltz, Perfidia, Beautiful Ohio.* This finally gave way to lively and stimulating music such as *Hot Trumpets, I Got Rhythm,* and *Boogie Woogie.* The authors attempted to select the music to meet the needs of the individual patients. Although this was not a controlled investigation, they judged their results to have been most encouraging. Many patients expressed enthusiasm for the music and called attention to its absence whenever it was omitted.

Murdock and Eaton[5] reported on their use of music before, during and after ECT. They believed that it could allay anxiety within the treatment situation and could assist in the reintegration and resocialization of the patient. The music was presented on records. Requests for specific music were fulfilled when possible, and reactions to such selections were noted. The music therapist judged the selections in such terms as rhythm, melody, timbre, emotional qualities, and dissonances. Final choices were left to the thera-

pist's discretion. Music before treatment tended to be soft, melodic, slow in tempo, and low or medium in pitch. It avoided excessive emotionality, marked rhythmic quality, or modern dissonances. It was intended to be calming and unobtrusive. In the post-treatment recovery phase, the selections gradually became more emotional and more rhythmical, to arouse the patient to activity.

Both classical and popular music were played. Whenever feasible, the music was adjusted to the patient's mood, psychiatric diagnosis, and affective tone. Vocal music was avoided. The authors could not evaluate their findings statistically, because many uncontrolled variables were present; but, in their opinion, the results were good. There was a distinct lessening of fear, and overt demonstrations of pre-treatment anxiety were almost completely eliminated. Patients awakened more peacefully and in a more pleasant frame of mind after treatment, and were more willing to go through the full course of treatment. Staff members who had been skeptical very soon became enthusiastic about the use of music. Music also acted to reduce the tension of assistants in the treatment room.

Leedy and Leedy[6] studied the effectiveness of music with ECT. They utilized the music techniques of Price et al.[4] and compared the results with those for patients who received ECT without music. Their patients received four treatments weekly, with an average of 20 patients a treatment day. Diagnostically, 72 per cent of the patients were schizophrenics, 10 per cent were manic-depressives, 10 per cent involutional psychotics, and 8 per cent organic psychotics with depression. Music was played during all three phases—the waiting period, the return to consciousness, and the ensuing period of bed rest. Leedy and Leedy reported their impressions of the effects as (a) decreased fear and decreased resistance to treatment; (b) heightened "morale"; (c) less tension during the waiting periods (no suicidal attempts when music was played during the waiting periods, in contrast to three such attempts during the preceding six months when patients were on ECT without music); (d) a more rapid return to consciousness after treatment, with diminished restlessness and fewer manifestations of terror—and fewer coitus movements and masturbatory manipulations in women; (e) a decrease in complaints of headache, dizziness, and nausea, also, a decrease in confusion; (f) a persistence of the quieting effect after treatment, with a reduction in the

amount of sedation required on the wards; (g) a decrease in the number of patients exhibiting psychotic excitements while on ECT; and (h) fewer and less intense postconvulsive excitements.

Bright jazz music, played during the recovery phase,[7] seems to induce more rapid awakening, and speedier departure from the recovery area. It influences the patient's subjective estimate of the passage of time following treatment. In contrast to other types of music, however, it may accentuate the confusion which follows immediately after an ECT session.

From historical review, it may be reasonably argued that the application of selected music before and during electric convulsive treatment seems to lessen the fear of such treatment. However, there is need for controlled, quantified evaluation of the action of music in this regard. A recent critical survey of the field of music therapy from the standpoint of psychiatry[8] emphasized the necessity for scientific procedures and impartial assessments in this field.

The present report is submitted as one step in the direction of controlled observation. It constitutes an objective study of the effect of selected music upon the degree of fear reported by psychiatric patients before and after electric convulsive therapy. An objective evaluation of that fear is also presented—with its development and its changes during the course of treatment.

Procedure

Subjects

The subjects were hospitalized male Veterans Administration psychiatric patients, receiving ECT. All 21 patients assigned to this treatment during the investigative period were included in the original experimental group. Two of these were excluded later as un-co-operative or manifestly unreliable.

The 19 remaining subjects were typical of those receiving ECT at the Albany, N. Y., Veterans Administration Hospital. Their median age was 40.9 years, Q_1=28.8 and Q_3=49.2. Their median educational level was 12.0 school years, Q_1=10.0 and Q_3=12.2. Vocationally, the majority of these patients were within the semi-skilled labor categories with occasional skilled labor and white-collar occupations. The diagnoses were seven schizophrenic reactions (four paranoid, two chronic undifferentiated, and one acute undifferentiated), nine depressive reactions (three of these

within psychotic limits), and three psychoneuroses with some associated depression.

Electric shock treatments were administered Mondays, Wednesdays, and Fridays, with an Offner apparatus, using the instantaneous technique modified by muscle relaxant anectine and sodium pentothal. The patients were brought to the ECT waiting room at 7:30 a.m. by a nursing assistant, who remained with them until the entry of the clinical psychologist at 8:30 a.m. Atropine was injected by the nurses at 8:15 a.m. The shock therapy commenced at 8:30 a.m. in a treatment room to which the patients were summoned individually. After his treatment a patient was brought to a separate recovery area. When he awakened, he had breakfast and then proceeded with the day's activities. A patient usually received three treatments weekly until the course of treatment was terminated, unless he was on "maintenance," when he had one treatment weekly or monthly. Treatment might be discontinued at any time for a variety of medical or administrative reasons.

Experimental Conditions

The three conditions compared were the control condition, Silence (absence of music); the experimental condition, Music A; and the experimental condition, Music B. Music A and Music B were contrasts of two general mood-types. Music A was calm, rather quiet, but not depressing. Music B was cheerful, mildly stimulating, and more rapid in tempo.

Since the purpose was to study the influence of pre-treatment music upon patients' fear of treatment, the music employed was of a sort most likely to be familiar to the patients—in mood, if not in the actual selections used. However, to minimize the possibility of monotony or a taking-for-granted of the "background music," the selections within each of the two music categories were varied in rhythm, tempo, and mood as much as possible within the limits and the playing sequence of the category. Thus, a smooth arrangement of a popular song might be followed by a waltz in lively tempo, which in turn might be followed by a rhumba, then a well-known popular song by a name band, and so forth. Vocals were included. The sound level was kept fairly constant. All music was presented on tapes of high fidelity.*

*Music and materials were made available by the Hospitalized Veterans Service, Musicians Emergency Fund Inc., whose assistance is gratefully acknowledged.

A representative selection of titles for the two categories follows:

MUSIC A

Special orchestral arrangements by Kostelanetz, Melachrino, and Mantovani of popular songs and Broadway show tunes.
Smooth, not too lively Latin-American selections: tangos, rhumbas, etc.
Till Then.
On Top of Old Smokey.
The Song is You.
Dancing in the Dark.
Selections from *Brigadoon, Annie Get Your Gun, Kismet, South Pacific* (usually in special orchestral arrangements).
My Silent Love.
April in Portugal.
In the Still of the Night.
Autumn Leaves.
Flirtation Waltz.
Sweetheart (from *Maytime*).
I'll Never Dream Again.
Tenderly.
I Still Get a Thrill.
In One Ear and Out the Other.
Deep Purple.
Love, Your Magic Spell is Everywhere.
Warsaw Concerto.
Time on My Hands.
Majorca, Isle of Love.
Over the Rainbow.

MUSIC B

Spirited Latin-American rhythms: rhumbas, boleros, mambos, etc.
Folk music, hill-billy, mountain, and Western-style music, all lively and appropriately orchestrated.
Catchy, rhythmical arrangements of happy, bright popular songs.
Polkas.
Marches, such as *Washington Post, King Cotton.*
When My Dreamboat Comes Home.
Wrap Your Troubles in Dreams (and Dream Your Troubles Away).
I Love You, I Love You.
St. Louis Blues (in mambo style).
Davey Crockett.

When You're in Love.
Mr. Sandman.
It's a Sin to Tell a Lie.
Cha-Cha-Cha.
Count Your Blessings.
You Are My Sunshine.
Blue Danube Waltz.
Tavern in the Town.
Naughty Lady of Shady Lane.

The three conditions (Silence, Music A, Music B) were presented in a random sequence for a period of 21 weeks, totaling 63 sessions. The conditions were varied weekly rather than daily, so that each condition would produce a cumulative effect. The separate conditions were not run for more than a week each in order that variables such as the effects of weather and season of the year be equated.

To carry through both experimental and control conditions (A, B, or Silence) to the very point of treatment and loss of consciousness, the same condition was maintained in the treatment area as in the waiting room. Thus, when there was Silence in the waiting room there was Silence in the treatment room. Music A or Music B in the waiting room was continued with Music A or Music B in the treatment room. The only difference was that music in the treatment room was supplied by records through a player of fair fidelity whereas music in the waiting room was supplied by tapes of high fidelity.

The Rating of Fear

Before implementing the experiment, a meeting was held with the ward personnel to explain the procedures. One nursing assistant was designated to start the tape recorder in the waiting room each treatment morning and to obtain the self-ratings of fear from the waiting patients. His instructions are reported here, together with the directions for administering the rating scale itself. This self-rating scale (see Figure 1) was developed *ad hoc.* It was sufficiently simple and rapid to be suitable to the mental condition of the patients. The scale covered a gradient of nine steps from *Neutral* or the absence of fear at 1 to *Very Scared* at 9. A patient's individual rating score was the number on the line 1 to 9, which was closest to his check mark.

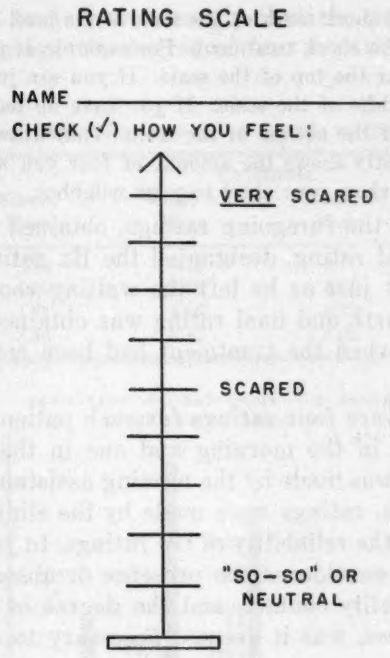

Figure 1.

Directions

Procedure and directions for administering the fear rating scale

Procedure: The aide will accompany the ECT patients to the waiting room at 7:30 a.m. Immediately, he will start the tape recorder and play the prepared music without stop. The volume control should always be set between the letters "U" and "M." The waiting room door should be kept *CLOSED* at all times. At 8:00 a.m., a few minutes *BEFORE* the atropine is brought into the room, the aide administers the rating scale to the patients. Pass out a scale sheet to each patient. Read the directions aloud to the patients. Go to each patient individually and have him write his name on the sheet and rate his fear by making a check mark. If a patient does not understand directions you may repeat them. Be very careful not to hint to the patient where he should place his check. As soon as a patient has checked the scale, pick up his sheet and turn it over so others cannot see it. It is important to the patient that his feelings be kept confidential even though he might brag that he doesn't care. A psychologist will arrive at 8:30 a.m. and will readminister the rating scale.

Directions to patients: Rate yourself as to how scared you are of shock

treatment. Place a check mark on the scale at the level of fear you *now, at this moment* have for shock treatment. For example, if you are very scared, you will check near the top of the scale. If you are just scared, you will check near the middle of the scale. If you have no fear about treatment, you will check near the bottom of the scale. Your answer to this question is right if it honestly shows the amount of fear you *now* have for shock treatment. Do not show your sheet to your neighbor.

In addition to the foregoing ratings, obtained at 8:00 a.m. and 8:30 a.m., a third rating, designated the Rx rating, was obtained from the patient just as he left the waiting room to receive his treatment. A fourth and final rating was obtained at 1:00 p.m. of that same day, when the treatment had been concluded and was well behind.

Hence, there were four ratings for each patient on every treatment day, three in the morning and one in the afternoon. The 8:00 a.m. rating was made by the nursing assistant. The 8:30 a.m., Rx, and 1:00 p.m. ratings were made by the clinical psychologist, who also judged the reliability of the ratings. In judging reliability the psychologist considered the presence or absence of confusion, the extent of reality contact, and the degree of co-operation. In only two instances, was it deemed necessary to discard the data as unreliable.

Results

1. *Influence of Music*

a. Comparison of experimental conditions

The raw data were searched for every patient who had experienced all three of the conditions (Silence, Music A, Music B), one or more times. There were 19 such patients, it will be recalled. The final score assigned to each patient for each condition was the mean of his ratings for that condition. The group means and the tests of statistical significance between conditions were calculated from these final scores.

Table 1 reports the group mean fear ratings (N=19) for each of the two experimental conditions and for the condition, Silence. Figure 2 portrays these graphically. At all time intervals, the greatest degree of fear was experienced under Silence; there was less under Music A, and least under Music B. These differences became more pronounced through the course of the treatment day. Although they did not attain the point of statistical significance (by *t*-test), the data were so completely consistent in their step-

wise gradient as to suggest strongly that the presence and type of music did influence the degree of fear experienced before and then after ECT.

Table 1. Mean fear ratings under the several conditions (N=19)

Rating Time	Conditions			
	Silence Mean	Music A Mean	Music B Mean	Combined Mean
8:00 a.m.	4.42	4.12	4.11	4.22
8:30 a.m.	4.89	4.38	4.35	4.54
Rx a.m.	4.71	4.45	4.31	4.49
1:00 p.m.	3.66	3.42	3.29	3.46

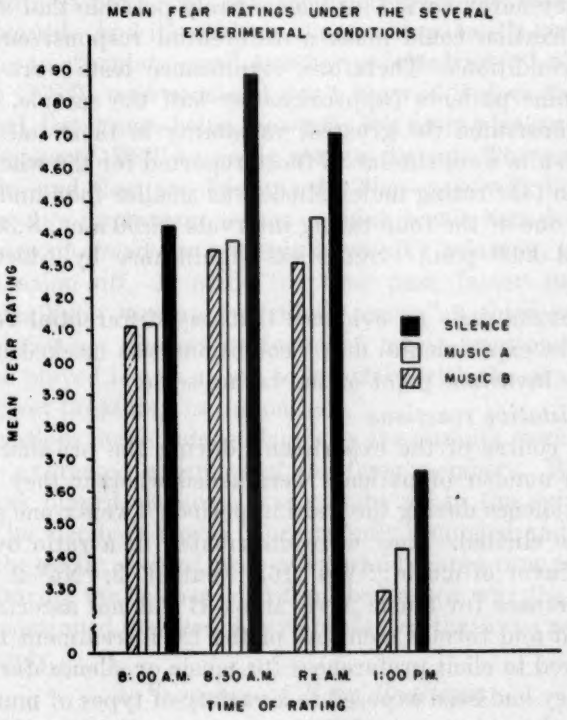

Figure 2.

b. Proactive effect of music

It is especially noteworthy that the differential effect of Music as against Silence in alleviating fear of ECT, was carried over

into the afternoon postshock fear ratings (Figure 2, 1:00 p.m.). This was a proactive effect of music, whereby it projected its fear-alleviating influence into a later time—after treatment. Such a proactive effect within the course of the *single* day, calls for the exploration of music as a method of minimizing the fear of ECT which ordinarily accrues and mounts through a full *series* of treatments.

c. Intra-individual variability

A review of the data made it apparent that some patients were much more variable than others in their self-rating fear scores. While some shifted considerably in score from rating interval to rating interval, others were rigidly fixed at single points from which they never varied. It was entirely possible that such an invariant fixation could mask a differential responsiveness to the several conditions. Therefore, significance tests were computed for the nine patients (approximately half the sample, N/2) who had demonstrated the greatest variability in their self-ratings.

The results were similar to those reported for the whole sample. The mean fear rating under Music was smaller than under Silence at every one of the four rating intervals (8:00 a.m., 8:30 a.m., Rx a.m., and 1:00 p.m.). Statistical significance by *t*-test was not attained.

The results gave no evidence that any differential responsiveness to the experimental music conditions was masked by fixation upon one invariant point of the rating scale.

d. Qualitative reactions

In the course of the experiment, during the pre-shock waiting period, a number of patients were asked whether they preferred music or silence during the waiting period. Twenty-one such opinions were elicited. They were distributed in a ratio overwhelmingly in favor of music: "Yes" 16, "Neutral" 3, "No" 2. The relative preference for Music A vs. Music B was not ascertained.

Current and former members of the ECT treatment team were interviewed to elicit preferences for music or silence *during* treatment. They had been exposed to a variety of types of music during their membership on the ECT team, before this experiment was begun, as well as during it. The 14 such team members interviewed included nine psychiatrists, three nurses, and two nursing assistants. Thirteen members favored music, one nurse was neutral, and none disliked it. The nurse who was neutral to music stated:

"I don't notice the music much. They play it all over the place, so after a while you ignore it. I do like polkas and Spike Jones." All other respondents were impressed by the decreased emotional tension in themselves and the treatment staff when the music was played during ECT. They all noted, too, that the music lifted their spirits. They expressed this variously as "better spirits," "a bit of cheer," or "gaiety." All but one preferred music with clearly punctuated rhythm. The majority preferred a popular type of music such as jazz and polkas.

One psychiatrist had this to say: "I like to hear music. It changes the atmosphere, makes it more comfortable and relaxed. ... It brings up associations which are different from the usual hospital atmosphere; [I like] jazz. Not the mood itself, but rather it must be well played. And it's early in the morning, so it's good to have something to stimulate one." Another psychiatrist: "I always preferred it [EST] *with* music. I don't know if it does the patients much good, but it sure helps the staff. It's more pleasant. It alters the atmosphere. EST to me is always dismal. The patients are pushed in, and they are frightened. They passively lie down on the table. It's unpleasant to me. I think music cuts down on the atmosphere of dread the patients have. It's relaxing, takes some of the tension off. It made the time pass faster subjectively. ... I prefer lively, accented rhythmic music." A third psychiatrist while expressing himself in favor of music, cautioned that "it should be played low so as not to interfere with the physician trying to detect breathing in the patient."

Observations made independently by the authors were consistent with the expressed attitudes of the team members. When lively music was played the team was caught up in the spirit of that music. The members moved more rapidly, hummed and tapped in time to the music, seemed more at ease and more prone to exchange quips. During the Silence condition they asked why the music had been discontinued and would have preferred that it be re-instituted immediately.

2. *Sequence of Fear Reactions*

The patients' self-ratings provided data for a quantitative study of the fear which accompanies electric convulsive therapy. In the foregoing, the mean fear scores under the several experimental conditions (Silence, A, B) were compared to ascertain the conditions' differential influence on fear. Now, from another aspect

and with a different purpose in mind, the mean fear score was computed at each time of rating for all conditions combined. This equated any possible differences between the effects of the three conditions (Silence, A, B), and permitted the analysis of change in fear reactions according to time of rating.

The mean accrual and/or diminution of fear at the four rating points within the ECT treatment day was ascertained. It is described under "a" following. Under "b" is described the mean fear gradient through the course of a cumulative series of ECT sessions.

a. Within the single day—a cross-sectional view

The mean fear ratings were computed for all conditions combined, at each one of the four rating periods of the treatment day (see Table 1, Column 4: Combined Mean). They were calculated from the scores of the 19 patients who had gone through all three conditions at least once.

The combined mean fear ratings at the several periods respectively were 8:00 a.m., Mn=4.22; 8:30 a.m., Mn=4.54; Rx a.m., Mn=4.49; 1:00 p.m., Mn=3.46. Tests of their statistical significance were made, each against the others. Table 2 reports the results of these *t*-tests. All were statistically significant except the 8:30 a.m. vs. Rx a.m. comparison. This comparison showed a slight drop in fear, but not great enough to approach statistical significance.

Table 2. Comparison of mean fear ratings at the several time intervals, all conditions combined (N=19)

Rating Periods Compared	Difference in Mean Scores	*t*	P
8:00 a.m. vs. 8:30 a.m.	+0.32	3.11	.01*
8:30 a.m. vs. Rx a.m.	—0.05	.71	.50
Rx a.m. vs. 1:00 p.m.	—1.03	2.47	.05*
8:00 a.m. vs. Rx a.m.	+0.27	2.54	.05*
8:00 a.m. vs. 1:00 p.m.	—0.76	2.32	.05*
8:30 a.m. vs. 1:00 p.m.	—1.08	3.93	.01*

*Statistically significant at the indicated probability level.

Figure 3 shows the direction and degree of change of these mean fear ratings over the course of the several rating periods within the treatment day. It portrays the group-mean subjective experience of fear for each of the three conditions (Silence, Music A, Music B) and for all three combined.

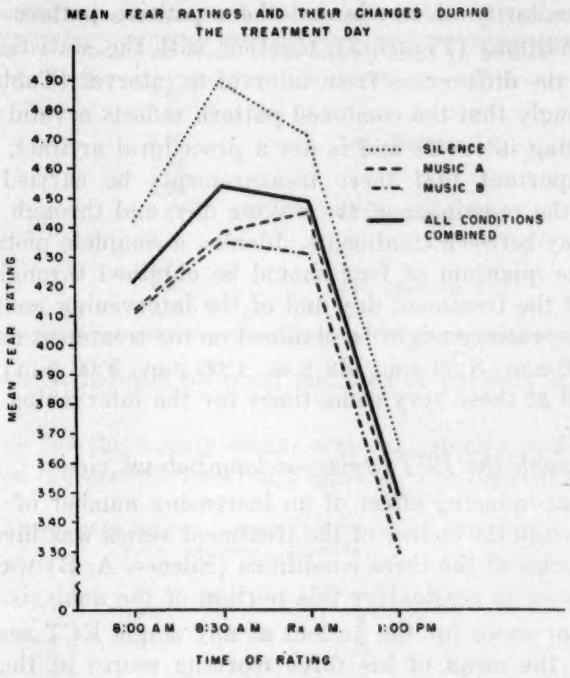

Figure 3.

The trends were very similar for each of the conditions, although the slopes between 8:30 a.m. and Rx a.m. showed somewhat greater variation than the slopes between the other time intervals. The increment in fear which occurred between 8:00 a.m. and 8:30 a.m. was not unexpected. Fear was heightened as treatment approached. Rather surprising was the slight decrease in fear between 8:30 a.m. and treatment time (Rx a.m.). One might have predicted a priori that fear would continue to mount until the very instant of unconsciousness. But this was not the case. Once the patient had entered the psychological region of ECT, once the treatment was upon him, his fear stopped rising and in fact showed some small decrement. The subjective experience of fear while awaiting treatment was apparently greater than the fear at treatment time itself.

The experience of fear showed a sharp decline after treatment, according to the combined mean at 1:00 p.m. This was significantly lower than any of the morning means. However, a definite residual of fear did remain (combined mean at 1:00 p.m.=3.46).

The similarity of trends and the repetitive pattern under all three conditions (Figure 3), together with the statistical significance of the differences from interval to interval (Table 2), suggest strongly that the combined pattern reflects a valid trend for these rating intervals and is not a procedural artifact. It would seem important that these measurements be carried forward through the remainder of the waking day, and through the intervening day between treatments. Ideally, a complete picture of the subjective quantum of fear should be obtained through the full course of the treatment day and of the intervening nontreatment day. Thus, ratings might be obtained on the treatment day at 7:00 a.m., 8:00 a.m., 8:30 a.m., Rx a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m.; and at these very same times for the intervening nontreatment day.

b. Through the ECT series—a longitudinal view

The fear-inducing effect of an increasing number of ECT sessions through the course of the treatment series was investigated. The influence of the three conditions (Silence, A, B) was equated from session to session for this portion of the analysis.

The fear score for the patient at any single ECT session consisted of the mean of his three morning scores at that session (8:00 a.m., 8:30 a.m. and Rx a.m.). Thus, if a patient rated himself 4, 7, and 5 respectively at the three morning time-intervals of his first ECT session, then his fear score for that first session was the mean of these, or 5.3. If he rated himself 6, 8, and 7 at the three morning time-intervals of session 2, then his score for that second session was 7.0 (i.e., their mean). Hereafter the terms "fear," or "fear rating," will refer to the score so derived.

The means of the fear ratings per session, and the weekly means of these session means, are reported in Table 3.

Figure 4 presents a graphic portrayal of the changes in fear through nine treatment sessions. It also gives the slope of the weekly means, based upon the session means (three sessions a week).

The general trend in Figure 4 was upward, although downward fluctuations did occur at individual sessions. These individual fluctuations conceivably reflected true departures from the upward trend, that is, reflected an interaction between fear and the specific session number. More probably, however, they were due to samp-

Table 3. Mean fear ratings per session in the treatment series, and their weekly means

Session	Mean Fear Score	Weekly Mean (3 Sessions)
1st	2.24	
2nd	1.87	
3rd	3.36	2.49 (Sessions 1-3)
4th	3.98	
5th	3.58	
6th	3.62	3.73 (Sessions 4-6)
7th	4.18	
8th	4.91	
9th	4.20	4.43 (Sessions 7-9)
≧10th	4.39	

ling variability, induced by small numbers of patients in the sessions.

The slope for the weekly means was consistently upward, and underscored the general trend of Figure 4. The mean fear scores

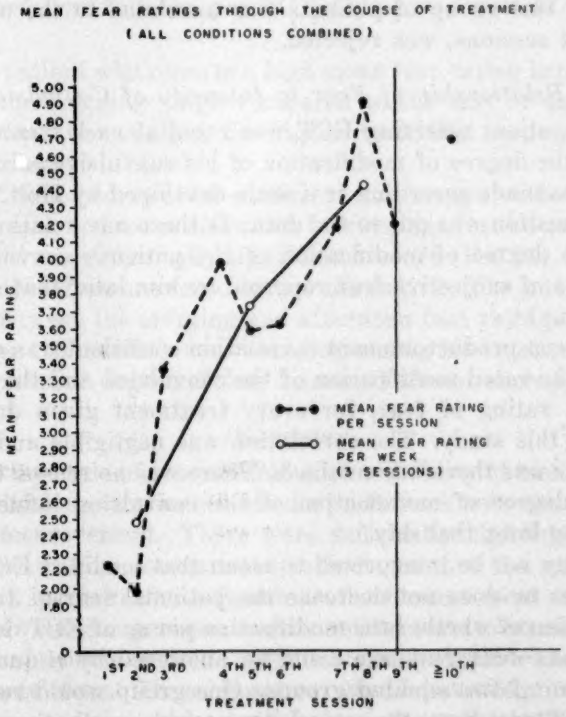

Figure 4.

continued to rise in the ensuing sessions after the ninth. The mean for all ratings at the tenth and later sessions extended the slope still farther upward (Figure 4, $\geqslant$10th).

The effect of the increasing number of ECT's on the fear rating, was investigated through the technique of analysis of variance. The fear ratings for the total of 19 patients were used. The range of treatments extended from one to nine with a sum total of 115. Some patients did not receive the full nine treatments. The results of the analysis of variance did not attain statistical significance, but the trend was strong enough to suggest significance if a larger sample or treatment series were used.

Accordingly, the analysis of variance was extended to include the tenth, eleventh, and twelfth treatments. It then gave a statistically significant finding at the .05 probability level. The results supported the hypothesis that a real rise in fear occurred as the treatment series was lengthened. The null hypothesis, that the fear score for this group of patients was unrelated to the number of treatment sessions, was rejected.

3. *Relationship of Fear to Intensity of Convulsion*

Every patient receiving ECT was rated at each treatment session for the degree of modification of his convulsive seizure. The rating was made according to a scale developed by Holt.[9] The following question was put to the data: Is there any relationship between the degree of modification of the patient's convulsion and the degree of subjective fear reported by him later that same day (1:00 p.m.)?

A Pearson product-moment correlation coefficient was computed between the rated modification of the convulsion and the patient's 1:00 p.m. rating of fear, for every treatment given during the course of this study. The correlation was negligible and the null hypothesis was therefore retained. There was no reason to believe that the degree of modification of the convulsion influenced the fear rating later that day.

This may not be interpreted to mean that modified ECT necessarily does or does not decrease the patients' fear of treatment. The question of whether the modification per se of ECT does affect the patients' fear response could be answered by a quantitative comparison of two equated groups. One group would receive the unmodified treatment; the second, comparable in all other respects.

would receive the specified modification. This question was not investigated by the writers.

4. *Stability of the Fear Ratings*

a. Test reliability of the rating scale

This concept of test reliability pertains to consistency of measurement. A reliable test or measure is comparatively free of chance errors of measurement. It is stable in the sense that subsequent applications yield no significant discrepancies in score. The original scores are highly correlated with scores at retest.

Rank order correlations were computed to ascertain the test reliability of the rating scale of fear. The reliability correlation coefficient for the mean morning fear ratings of a sample of 25 patients was +.90 ($P<.01$). The reliability correlation coefficient for their afternoon fear ratings was +.91 ($P<.01$). The rating scale of this study is a reliable method of measurement.

b. Correlation between pre-ECT (a.m.) and post-ECT (p.m.) ratings

Does a patient who reports a high mean fear rating before treatment in the morning—high compared to the rest of the patient sample—tend to maintain his higher rank that same afternoon after treatment?

A rank order correlation coefficient was computed between the mean morning and mean afternoon fear ratings for the group. This correlation was statistically significant at +.78 ($P<.01$). The question was therefore answered in the affirmative. The intercurrence of ECT between the morning and afternoon fear ratings had little effect upon the patient's rank standing among his treatment mates. His comparative degree of fear remained almost unchanged.

Discussion

The rating scale of fear showed high reliability of measurement. Its statistical application assumed equidistance between the scalar units of measurement. There were sufficiently high consistencies in the quantitative comparisons to indicate that the rating scale adequately performed its function: the measurement of fear. It permitted valid comparisons and statistical tests to be made. Other and more elaborate methods might have been employed to measure the patients' fear. These, however, would have required a high level of co-operation and attention from the patient. They would

have required careful reading and exacting deliberation; nor would they have been sufficiently brief to permit repetitive administration, several times within a short interval. Rapid re-administration was necessary to the experimental design.

The present writers used the term "fear" rather than "anxiety," since so much of the fear of ECT was a reasonable reaction to a powerful and admittedly uncommon (outside of psychiatric settings) treatment method. Gallinek[10] classified the fear of ECT in several categories. These included reasonable apprehension, somatogenic fear, unreasonable concern in premorbidly anxious patients, and fear of treatment integrated into the structure of the psychosis. The term "fear" was used broadly to include all these types. A clinical review of the patients in the present sample underscored the presence of Gallinek's category "reasonable concern." The categories "unreasonable concern in premorbidly anxious patients" and "fear of treatment integrated into the structure of the psychosis," were only minimally present in the writers' group. This was surely due to a difference in the populations sampled.

This report has described the group response of patients under specified conditions. Its methodology demanded that the data be structured to bring out group and general trends, while randomizing or equating individual differences. Continued research inquiry is necessary to assay and to understand the individual differences in response.

The reasons for patients' individual differences in the experience of fear require elucidation. What leads one patient to a maximal rating of fear and another to a minimal rating? Are factors such as age, intelligence, or diagnosis pertinent to this issue? Gallinek[10] did not observe any congruence between proneness to fear of ECT and sex; nor, with the exception of patients having paranoid and anxiety features, between treatment fear and psychiatric diagnosis.

Does the psychological preparation of the patient for treatment play a role in his experience of fear, and if so to what degree? Does the quality and intensity of his relationship with his own physician or therapist lead to mitigation of fear? Qualitatively, a psychological defense such as "denial" may serve to lower the fear rating. Again, the need for succor and support may cause

the patient to raise his reported degree of fear. He may wish to show how much he requires help.

The patients in the present inquiry showed wide differences in the variability of their fear ratings. Some were rigidly fixed upon a particular score; they shifted upward or downward only infrequently. Others showed great flexibility in their ratings. What is the basis within the individual patient for the rigidity or flexibility of his fear rating? Does elasticity (or its lack) reflect a fundamental trait? Does it reflect the patient's general mode of response to a fear-provoking situation of stress? These questions direct attention to important lines of investigation.

Music has differential effects upon the various psychiatric categories of mental illness. Familiarity, too, may determine the effect that it has upon the emotions. Music may evoke any one of a wide spectrum of reactions, depending upon the perceptual readiness or set of the listener and the gestalt of the music stimuli.[11]

The desirability of individualizing the music at ECT has been commented on by music therapists. They have emphasized the need to meet the special requirements of the individual patient. Nevertheless, practical administrative reasons dictate that electric convulsive treatment in active psychiatric departments be given on a group basis. This reduces markedly the scope for individualization of music therapy adjunctive to ECT. The music therapist must program his selections for the group rather than for its separate members. He must think in terms of the group's characteristics and is constrained to plan broadly for the whole. Within these limits, the individualization of music therapy is to be encouraged.

The experiences reported here give evidence that the group approach can be effective. The writers' patients expressed a decided preference for music over silence during the ECT waiting period, despite the complete absence of individualization of the music. The patients' quantitative fear ratings also reflected the ameliorating influence of music in spite of the group setting.

Consideration should be given to the significance of music for the electric shock treatment staff. In the present survey, the treatment team's desire for music was almost unanimous. Active, stimulating music exerted a decidely favorable influence upon the spirit and morale of the treatment staff. This reaction in and of itself can have a favorable consequence for the treatment of patients.

It does so by altering the treatment milieu toward an attitude of relaxation and fellowship.

Music, especially of a stimulating type (Music B), consistently reduced the patients' fear of treatment (Figure 2). These experimental findings confirmed the clinical observations [1, 3-6] that music alleviates fear of ECT and exerts an ameliorative influence.

Music may therefore have a not-inconsiderable adjunctive value for ECT. It provides, in part, a method for the control of the patient's affective response to the therapy. It can mold his subjective definition of the treatment situation.

One might hypothesize that music, particularly of the Music B type, has a quality demanding attention. It commands or grasps the subject's attention. Thereby it reduces the degree and intensity of introspection and hence of inner fear.

In this study, music was restricted to the pre-treatment period up to the point of application of shock. It was not brought over into the recovery phase. The proactive influence of music was apparent. It exerted ameliorating action which was projected into the postshock period later in the day (Figure 3, 1:00 p.m.). The added presentation of music during the recovery phase might yield a still greater ameliorative action and heighten its adjunctive value for ECT. Qualitatively this beneficent effect has been described[4-6] but experimentally it has not yet been demonstrated. There is strongly suggestive experimental evidence that music during the recovery phase does influence some aspects of the patient's response, but this evidence is not directly concerned with the matter of treatment fear.[7]

The course of fear within one treatment day (Figure 3) showed an unexpected trend downward from the 8:30 a.m. rating to the Rx a.m. rating. In the course of the treatment day, therefore, the greatest fear develops during the waiting period. It then declines, from the moment the patient enters the active region of treatment. This suggests that efforts to alleviate fear should be directed primarily toward the waiting period and secondarily to the other treatment phases.

Gallinek[10] found, by interview, that fear increased with the progression of ECT's. Kalinowsky[12] concurred with Gallinek and voiced the psychiatric opinion that fear did usually grow as treatment progressed. The results of the present study were wholly in accord with Gallinek and Kalinowsky. These results, derived from

a sequential quantitative analysis of patients' fear of ECT, gave evidence of a cumulative rise in fear, as the treatment sessions increased in number (Figure 4).

Kalinowsky and Hoch[13] observed that fear of ECT was a greater problem than had been originally realized. They reviewed the literature pertinent to fear of treatment. The present writers have already touched upon the possible disparity between modified and unmodified ECT in instigating fear (see "Results," in the foregoing). Holt[9] discussed some implications of modified ECT in connection with fear of treatment.

The technique of ECT administration, including the method and type of modification of convulsion, may play an important role in the arousal of fear and in its subsequent vicissitudes. There may be significant interaction between the specific technique of ECT and the influence of music upon the fear which is stimulated by that ECT. It is therefore necessary that reports of research dealing with fear of ECT and the influence of music upon such fear, specify the method of ECT administration. This has generally not been done in published descriptions of the use of music with ECT.

The findings of this study should not be taken to indicate that music augments or improves the effectiveness as treatment of ECT. This question was not posed as a problem for investigation, nor can the data in this paper shed light on it. Indirectly perhaps, music may assist ECT by decreasing the patient's fear and hence inducing him to enter or remain in treatment.

Experimental inquiry into the amelioration of treatment fear through music should be extended to include the comparison of "live" with recorded music. Piano or other instrumental music, played by the musician within the ECT waiting room, might have more powerful consequences than the same music played from a record.

Summary

Hospitalized male psychiatric patients, undergoing modified electric convulsive therapy, rated the degrees of fear they experienced while awaiting treatment. Each patient made three such ratings during each morning pre-treatment waiting period, and rated himself once more several hours after treatment (8:00 a.m., 8:30 a.m., Rx a.m. or time of entering treatment room, and 1:00 p.m.). The morning pre-treatment ratings were made under three experimental conditions: Silence (absence of music), Music A

(slow tempo, "calm" popular music), and Music B (popular music of more rapid tempo).

The mean fear ratings between conditions were compared; tests of the statistical significance between differences were made. In each instance and at every rating interval, the mean intensity of fear was greatest under Silence, less under Music A, and least under Music B. Although the tests of the differences among these various means did not attain statistical significance, the direction of the difference and the stepwise gradient in every case was so consistent as to suggest very strongly that music applied during the ECT waiting period did alleviate fear. A stimulating type of music appeared to be the more effective medium in this alleviation. Music before ECT had a proactive effect upon fear after treatment. The mean fear score after treatment was lowest when music had been played before the ECT; it was highest when there had been merely silence before treatment.

Intra-individual variability in the ratings of fear was considerable, but special tests gave no evidence that this quality of rigidity or flexibility of rating masked a responsiveness to the influence of music. A survey of qualitative opinions by the treatment staff and by the patients revealed marked preference for music during the ECT waiting period and treatment session.

The sequence of fear reactions through the course of the day was quantitatively evaluated. The intensity curve of fear rose steeply from 8:00 to 8:30, then flattened out at treatment time (the moment the patient left the waiting room), and, after treatment, showed a decided drop to its 1:00 p.m. rating point. Statistical tests of significance were made for the mean fear scores at these four rating intervals. They showed a significant degree of change in the curve among the several rating points.

A longitudinal statistical analysis was made of the intensity of fear experienced by patients over the course of the ECT series. There was a definite accrual of fear from the first treatment through the twelfth and later treatments. The general trend of fear was consistently upward, with analysis of variance significant at the .05 probability level.

A statistical test gave no evidence that the intensity of fear following the treatment session was related to the strength of the seizures at that session. There was no reason to believe that the

degree of modification of the convulsion influenced the fear rating later in the treatment day.

Measures of the rating scale test reliability were obtained. Reliability coefficients were .90 ($P<.01$) and .91 ($P<.01$). It was also ascertained that the intercurrence of ECT between the morning and afternoon fear ratings had little effect upon the patient's rank standing among his treatment mates. His comparative degree of fear remained almost unchanged by the intercurrence of ECT.

The implications of these findings were discussed and lines of future investigation indicated.

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AN EGO APPROACH TO PSYCHOTIC BEHAVIOR*

BY GORDON R. FORRER, M.D.

This paper records the planning, execution, and some of the results of an organized effort to deal psychologically with psychotic behavior in a large state hospital. Each week, at Northville (Mich.) State Hospital, there is a regularly scheduled seminar for the psychiatric nurses, conducted by the clinical director. At its inception, the attending nurses were assigned in rotation to make case presentations. Only later was the wisdom recognized of having the nurses select cases of their own volition and choosing. One nurse acts as liaison officer between the nurse group and the clinical director.

The individual nurse may now choose whether to present a case and has freedom to present the one which is of greatest interest or concern to her. Where originally, there was some dread among nurses of being selected to make a case presentation, there is now, not infrequently, lively competition to do so. With this technique, the quality of case presentations has improved immensely, and the enthusiasm in the nurse group for the seminars has risen to gratifying levels. The format of case presentation is flexible and is left up to the nurse making it.

More often than not, the nurse does not consult the patient's record or present material from it. Experience has been that case record material frequently has little relevance to the behavioral problem at hand and may serve only to prejudice the nurse and interfere with her relationship with the patient. Case record material is so frequently distorted and slanted in one direction or another, depending upon the orientation of the person who recorded it, that it was felt that the nurse should not use it. Ego deficits may be described in a case record in minute detail, with only a passing reference to ego capabilities and little or no assessment of maturity potentials. This is in keeping with the medical tradition of emphasizing pathology and minimizing normality and can hardly be otherwise when the question society demands is, "How sick is the patient?" rather than, "How well is the patient?"

The seminars are not designed to make diagnoses; and, in fact, diagnostic terms are rarely mentioned. The entire effort revolves

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about the definition, description, and estimation of ego strength. The purpose of the seminars is implied in the question, "What can we do, what can we say, or how can we act to make it possible for the patient to conform more adequately to reality?" The nurse, by confining her presentation to her direct observations and those of other members of the ward personnel, is on firm ground, unfettered by expressions of opinion as to diagnosis and estimates as to prognosis. The patient's ward behavior, activity, and relationships with others are given in detail. A great deal of emphasis is placed upon critical observations, and a statement such as "The patient became disturbed," is discussed in detail with all of the surrounding circumstances. The "How?" "Why?" "Where?" "With whom?" and "In what manner?" of a patient's behavior are exhaustively examined. Experience demonstrates that clues for understanding are hidden among the details.

It is conventional for the nurse to have an understanding, accepting, and sympathetic attitude. Beneath conventionality, lie her real feelings toward the patient. One achievement of this program has been the fact that in the seminar the nurse has felt free enough to express what she considers those real feelings. To have a nurse say, "I got so mad when he did that, that I could have turned him over my knee and spanked him," or "I felt like slapping him in the face," may not seem "worthy" of a person who is supposed to be helping another; but these are the kinds of feelings human beings some times have, and it is realistic to recognize them. No attempt, of course, is made to interpret a nurse's counter-transference; a practice which, in the writer's mind, would be disturbing and far from valid under the circumstances. The nurse seems to feel more secure and, subsequently, more effective as a nurse when her reactions to the patients are explained in terms of, "There is an unconscious motivation in the patient which makes you feel the way you do about him. He invites a certain behavior from you, just as earlier in his life he invited a certain kind of behavior from other people around himself. Your understanding of his unconscious motivations will help you in dealing with his behavior, in a way that will benefit him." It is, in the writer's opinion, threatening to the nurse and disruptive to her effectiveness to make unwarranted attempts to analyze her reactions.

After the nurse has presented the case, the patient is interviewed. The emphasis in the interview is on the patient's hospital

activities and relationships with others in the institution. Personal history material is virtually ignored, and it has been the writer's distinct impression that most patients find this a novelty not always to their liking. Some of them are puzzled because the traditional questions are not even asked. Some are surprised that so much interest is given to their daily current affairs. The interview's emphasis upon the current reality situation and on the patient's appraisal of himself, gives valuable information in estimating ego strength, flexibility, and reaction to stress; factors so important in the future planning of therapeutic endeavor.

The patient as a person is emphasized, rather than the patient as an appendage to a long and extensive history of illness. After the patient leaves the interview, there is discussion, and formulation of a plan of management. If the ward physician's approval is required for the particular plan evolved, the nurse goes to him and tells him the results of the conference. The ward physician then approves, or disapproves. As a rule, he is only too glad to give what orders are necessary; and when he does not do so, he discusses his reasons with the nurse.

The ward physicians have found this procedure so helpful that, very frequently, they ask a nurse if she will present a certain patient to the seminar. Since the doctor on the ward makes all the decisions as to what therapeutic measures will be instituted, there is no clash or conflict between nurse and doctor; and, remarkably, there has been no single instance of a physician complaining that nurses were trying to do psychotherapy. The writer firmly believes that this is principally because the nurses work under doctor-direction and put no therapeutic or management measures into effect without his support and approval. The nurse feels much more secure working under these circumstances; and the physician does not feel threatened, because nurses are not carrying on "therapy" outside his immediate control and direction.

The policy of the management of psychotic behavior at Northville State Hospital is based upon two functional premises. The first of these is that each time a psychotic person behaves in a way which is objectionable to himself or his social milieu, the perception of such unacceptable behavior is threatening, frightening, anxiety-producing, and disrupting to the ego. Permitting or encouraging psychotic behavior, or accepting it as an unalterable facet of the patient's personality, leads to regression and to an extension of

the psychotic process. The second premise is that no one can make another person do anything without the agreement and compliance of that other person at some level of behavior. Patients can be appealed to, through their transference relationships with the nurse, to behave in a more rational and more mature manner. The cases to be presented will demonstrate this.

The essential factor in the alteration of psychotic behavior is a relationship between the patient and the therapeutic person. There are very few psychotic patients who are not capable of forming some kind of libidinal relationship with the nurse; and each and every one of the failures in this program can be attributed to the lack of sufficient positive transference. It should be emphasized that the cases presented do not represent therapy in terms of getting the patient completely well, but only therapeutic episodes which have made possible more maturity and better adjustment in the hospital situation. The aims are modest—which, realistically, they must be.

Case 1

H. C. was presented by a nurse who brought him up for consideration because she felt she couldn't deal with the delusions which he constantly expressed. He felt that a machine controlled him, could not understand the necessity for his confinement, and believed that he had been tricked by his wife who, for reasons of her own, had had him committed. He was angry at the hospital for not releasing him. During the interview, an effort was made not to elicit any psychopathological material. It was felt that the patient had a great deal of ego strength and that, in spite of the severity of his illness, there was a considerable element of truth in his assertion that hospitalization was not necessary for him.

It was suggested that the ward doctor prescribe a responsible work therapy assignment, that the nurse emphasize to the patient how well he was doing, and that every effort on his part to talk about his delusional ideas be "squelched." The nurse co-ordinated the physician and the personnel on all three shifts in this plan. For the following three weeks, the patient tried to continue his previous behavior of bringing up the subject of "the machine," which was controlling him, but would be told, "That is your opinion but I don't see how it is possible." The patient was then immediately directed to other activity, for which there was consistent and realistic appreciation.

At the end of three weeks, spontaneous pathological verbalization ceased. The patient performed exceedingly well on his work therapy assignment, began going on leaves of absence with his wife for progressively long periods, and, in several weeks, left the hospital on convalescent status.

Case 2

A. D. was a withdrawn, hesitant, man who would not leave the ward, go for walks, or engage in other activities. The nurse who presented him emphasized that he would never look anyone in the eye when talking to him. In the interview, he would not look at the examiner and was very reluctant to talk. The suggestion was made that considerable pressure be put on the patient to have him look the nurse or any other person in the eye when talking to her. The nurse communicated this plan to personnel on all shifts. The patient began to come to personnel asking for assistance, particularly during the confusional period following electric shock treatments—which the patient was receiving at the time he was presented. It was suggested that everybody give him support and, "Let him know you are there if you feel he needs it." The patient, subsequently, became considerably more outgoing, engaged in activities, and began behaving in a much more rational fashion. He is now going out of the hospital on brief leaves of absence.

Case 3

B. T., a woman patient, was presented at the seminar because each time she was asked to help in ward activities she pleaded inability because of malaise and vague pains in the face. The nurse had the distinct impression of a histrionic quality to the patient's complaints, but had previously accepted them as a reasonable excuse for not carrying out work therapy assignments. When interviewed, the patient began to launch into a detailed account of her aches and pains, but the examiner swept these aside and insisted on dealing only with the current reality situation. It was recommended that the patient's physical complaints be ignored and given no credence. Shortly after this policy of management was instituted, the patient appeared enough better to her ward physician to be assigned to work therapy in the stenographic pool and in housekeeping. She carried on a double therapeutic assignment, with a marked decrease in the frequency of her somatic complaints; and later, she was not even mentioning them. It is hoped that arrangements can be made for her to leave the hospital soon.

Case 4

M. N., another woman patient, was a new admission who was markedly disturbed and refused to take sedative medication by mouth. She would spit out her pills. Intramuscular injections were resorted to, but medication did not affect her rejecting behavior at all. It was suggested that the nurse be silently insistent that the patient take the medication by mouth, staying with her as long as required, even if it meant the neglect of other duties. This suggestion was put into action, and the nurse would sit by her for as long as half an hour, silently holding out the medication. At last the patient would say, "O.K., you win, I'll take it." In 10 days or

less the patient took her medication willingly by mouth and has now improved in other respects as well.

Case 5

G. H., a male patient, was presented by a nurse because, although initially he had been underweight, he had shown an immense weight gain in a few months. In the last month or two various medications had been tried and his food had been limited, with no success. A tremendous amount of effort by the nurses had gone into trying to get the patient to control his intake of calories. The interview was rather unproductive, the patient was retarded and showed very little interest. It was suggested that the weight problems be ignored. The nurse had a talk with the patient and told him that if he really wanted to lose weight, he would have to do it himself. For the first week or two, there was no change in the patient's overeating. He then came to the nurse spontaneously and told her that he was himself cutting down his food. He then began to engage in vigorous sitting-up exercises in the evening—in company with several other patients who had organized themselves for the purpose. In two months he lost 25 pounds, became considerably more active on the ward, and began to go out of the hospital on leaves of absence. On one leave of absence, he got a job; and his ward physician decided he was well enough to leave the hospital on convalescent status.

Case 6

R. A. was presented at the seminar as a completely self-centered woman who would "faint" at inconvenient times, complain of physical illness, and use her complaints to justify not going to her meals. Before the conference, this patient had had her meals taken to her on the ward, instead of going to the cafeteria. It was suggested that the patient be told that she must either stop this behavior or be placed in seclusion. The feelings the patient brought out in the nurse are well demonstrated in the nurse's statement, "We threw her in seclusion." After one experience with this kind of management, the patient immediately and dramatically changed her behavior. She went to her meals co-operatively and willingly, and, as the nurse said, "stopped all this flopping around and started trying to help herself." This patient is still in the hospital, but her behavior is much closer to the normal.

Case 7

A. O. was constantly disrobing herself on the ward and causing much consternation among other patients and personnel alike. It was suggested that the nurse say to the patient, "I know you don't want to do these things but that you find it hard to control yourself. I am going to help you control these impulses by putting you in a seclusion room, if you un-

dress again." The nurse spontaneously added, "I know you're a woman, and you don't have to demonstrate it all the time." A week afterward, following liberal use of the seclusion room, the patient became much quieter and stopped undressing. She came to the nurse and said,"Thanks for helping me and seeing me through the acute stage."

Case 8

I. Y. was brought to the seminar by a nurse who reported that she was completely un-co-operative, lying around on couches, and refusing to take part in any ward activities. The interview was not particularly productive. The patient complained vaguely about feeling bad and said she would co-operate if only the doctors made her feel better first. It was suggested that the patient be firmly pushed into work therapy, that all her complaints be ignored and that members of the personnel constantly insist that she was capable of performance despite her protests to the contrary. The ward personnel worked closely with the patient for a month. At first it was necessary to hold her hands on the brush, as she was encouraged to scrub a wall or a floor. Her complaints decreased, as her capacity for working increased. The patient now has a regular work therapy assignment, which she goes to without complaints, and where she performs quite adequately. She has been going out of the hospital on brief leaves of absence and has a privilege card.

The cases reported here represent a sampling of those which have been handled by a firm, realistic, and objective approach. Essentially, the nurse has insisted that the patient has more ego strength than the patient is able to recognize. Superficially, it may appear that the patients have been forced to perform, but if one gives this some consideration, he will see that without the patient's compliance and agreement, conscious or unconscious, no such results could have been achieved. The achievement has been the patient's. The nurse and physician have only provided the circumstances favorable for better integration of the ego functions. In each instance, a relationship has developed between nurse and patient which, one may speculate, is closely akin to the relationship between a reality-oriented mother and a narcissistically-oriented child. None of the failures have been recorded. They have been very few. Although no figures have been kept, the nurses agree among themselves that "This method works in at least 95 per cent." This is probably too high an estimate, but the amount of success encourages a great deal of enthusiasm among the psychi-

atric nurses that is undeniably of great therapeutic benefit to the patients.

Summary

This paper outlines the organization and technique of a system of managing psychotic behavior, utilizing the transference relationship which develops between patients and personnel. Its aim is the strengthening of the patient's ego. Its purpose is the binding of instinctual impulses through adherence to reality. Its effect is the re-repression of psychopathology and the enhancement of object relationships.

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A TRIAL OF PATIENT GOVERNMENT

An Experiment Conducted at the New York State Psychiatric Institute

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The following paper is an account of a trial of "Patient Government"—patient participation in the ward administration of a psychiatric hospital. This was, and is still being, conducted at the New York State Psychiatric Institute on a relatively open convalescent ward. These particular observations were made over a 20-month period, from October 1955 to June 1957. The trial grew out of mounting feeling among the patient population that the ward rules and regulations were unnecessarily rigid and confining and were too often imposed arbitrarily and without consideration of the individuals affected. The patients desired more freedom and latitude. They complained that many of the staff were too authoritarian and dogmatic in their approach. The staff, on the other hand, often interpreted noncompliance with long-established regulations as indicative of inadequate response to treatment; consequently, staff members often advanced the argument that if a patient could not perform as was expected, he was demonstrating behaviorally that he was not yet ready for transfer to an open ward. At the same time, all who were involved in the care and management of patients were increasingly aware of difficulties which many patients experienced when they were urged to take steps to leave the hospital and return to a functional existence on the outside. These difficulties were often vaguely described as dependency manifestations or "chronic hospitalitis." But whatever they were, they were presented often enough to warrant re-evaluation of the hospital program.

It was at this point that a trial of patient government was proposed. Nothing of this sort had ever been tried in the Psychiatric Institute before, so that no one involved had any objective basis for specific expectations from the experiment. But at the same time, the idea raised some questions as to the validity of hospital regulations and as to the possible therapeutic effect of patient participation in ward administration. Would such participation evolve into a system of self-regulation which would satisfy administrative necessities and at the same time allow greater freedom

to patients? Would this heighten group morale and thus promote socialization? Would this inhibit acting-out tendencies and foster more adequate reality testing? Would this increase individuals' awareness of their problems and thus afford material for psychotherapeutic sessions?[1]

Reference to the literature available on the subject did not bring definitive answers to these questions, but the reports did outline certain areas where benefits, or at least changes, could be anticipated.[2] The reports of the earlier investigators were generally favorable to "patient government," and among improvements noted were: enhancement of freedom of expression and self-determinism;[3] the re-acquainting of patients in an older-age group with their own constructiveness;[4] encouragement of patients to make better use of talents and capacities which were not impaired, and to try out new patterns;[4] development of self-awareness in patients and stimulation of patients to introduce more relevant interpersonal issues into the treatment sessions;[5] modification of anti-social behavior through peer pressure by affording structured social controls,[6] and development of attitudes of shared responsibility and authority;[5] and more ready entrance of withdrawn patients into reality situations, as a result of the group organization.[7]

Hyde and Solomon[8] reported on a trial of patient government with a group of patients similar to those considered in the present investigation, and in a hospital setting which also bore a strong resemblance to the Psychiatric Institute. They outlined their objectives in instituting patient government as: affording experience to patients in democratic living and promoting mutual help in improving environmental conditions and interpersonal relationships with staff members and with other patients. They felt that there were several accomplishments attributable to the patient government program. Withdrawn or depressed patients had an opportunity to express themselves in the group meetings, because the topics discussed interested them in some way. Conversely, the overactive patient, who tended to dominate in the group, was helped to see himself more clearly through the eyes of his peers and was thus guided in his social behavior. All the patients had the experience of exploring a reality situation, analyzing their own needs and working together toward constructive goals. This same group of patients became better able to under-

stand the basis for hospital rules and routine. The rules ceased to be arbitrary dictates and became reasonable organization principles. A patient-personnel relationship developed, in which interest in, and enthusiasm for, the project was shared over a long period, and the staff had a feeling of satisfaction at being included. Perhaps the most significant result of the Hyde and Solomon study was the improved morale among patients. They felt themselves to be important participants in something which concerned them vitally, and they had the opportunity to experience themselves and to test their new strengths in a nonthreatening group.

It has already been noted that the Psychiatric Institute's trial of patient government was initiated in response to rising discontent on the part of patients and staff members alike. One of the writers happened, at this time, to be the therapist for several of the patients, while the other was the ward administrator. The therapist had wondered if some of the responsibility for ward management might not be assumed by the patients themselves. It was thought that perhaps the constant difficulties which arose with respect to rules and routines might be handled by the patients rather than by the staff. If this was successful, the "griping" directed toward the nurses, attendants and any other staff members concerned with the management of the ward would be reduced. If a specific complaint arose, it would be in the power of the patients to discuss it, to examine possible alternate courses of action and to experiment with one or the other. Becoming involved with a problem in this fashion, they could better understand why the difficulty had arisen and might be more interested in a satisfactory solution of the problem.

The idea of patient government was presented to the patients. They were told that if they wanted to work on it, they should talk to the therapist who would work with them in an advisory capacity. Nothing was heard from the patient group for about two weeks. Then, the therapist was approached by individual patients who wanted to know when they were going to start the project. These patients were reminded that they had been asked to let the therapist know if they were interested. They had apparently been waiting for "the next move" from some authority figure. When they realized that it was up to them, they decided to meet as a group and discuss the formation of a patient group. Most of the patients were favorably disposed to the idea of such a group, and they

elected officers and began to set up an organization. They met with the therapist and requested that she meet with the officers once a week to discuss problems of organization or anything else which merited attention. Throughout the experiment, this same therapist remained with the group as their adviser and maintained liaison with the administrative staff. As adviser, the therapist had no official function within the group itself, but was used, rather, as a sounding board, from whom patients could obtain an opinion as to the feasibility of whatever plan was forwarded.

Agreement on procedure was reached between the patient group and the administrative staff. The group's function was to meet to consider any problem raised by the patients, endeavor to suggest a remedy satisfactory to the group, and work out a realistic plan for executing the proposed remedy. When this was done, the plan was submitted to the administration for approval. After approval, a plan was placed in operation as soon as the departments affected had been notified of expected changes. If approval was withheld, the reasons were discussed with the liaison psychiatrist, who then reported back to the patient group. In all instances, the patients accepted the administrative decision, or, upon consideration of the reasons for a refusal, were able to work out a modified plan which fell within the limits defined by the administrator.

The initial suggestions and plans of the patients revolved about social programs within the hospital and increases in privileges to implement such plans. One of the first requests was for the installation of a pay telephone on the convalescent floor. Many of the administrative group were more than dubious about the request. Nursing personnel pointed out that granting it would greatly increase the time spent by the individual patient in making telephone calls, that this would possibly interfere with scheduled ward activities, that the telephone number would be given to outside friends and relatives of patients, and that the telephone would perhaps be ringing all day and even all night long. Others in the administrative set-up recognized these as possibilities, but wondered, at the same time, if the patient government would not —if told of these original objections—exercise a certain amount of control over its members so that gross abuse of the telephone privilege would not occur. It was finally decided that the request, insofar as the administration was concerned, could be granted.

Application was then made to the telephone company which surveyed the situation in general and then failed to grant the request, because of lack of assurance that the requisite minimum of telephone calls a month would be made. The administration felt, however, that the original request had been a legitimate one, and in the end, saw no great objection to devising some set-up which would allow freer access, by patients, to a telephone. A plan was finally worked out with the nursing staff to make a telephone on a specific floor of the hospital available to patients at certain times, with the understanding that the privilege would not be used in a way to interfere with scheduled activities. The original request by the patients was made on November 10, 1955, and by the end of that month the new system was put into effect. At the time of the present writing, the arrangement is still in effect; and, to date, it has not been abused to an extent to cause the privilege to be withdrawn at any time.

Other suggestions made at about this time concerned:

1. A weekly social with an exchange of visits between male and female floors, a proposal that, furthermore, involved refreshments and the kitchen staff.
2. A cigarette and coffee break in the middle of the occupational therapy time.
3. Use of the ward dining room as a game room during the socials, when the larger day room would be in use.
4. Suggestions to the dietician's department as to specific foods.
5. Hours of undressing and going to bed.

When the patients came to realize that this new experience in patient government was more than transient, they began to think of forming a constitution for the group. A committee was appointed for this purpose. Following is the document they drew up. It was very closely patterned upon that of a similar group in another hospital.[3]

CONSTITUTION

ARTICLE I—Name

The organization shall be known as the "Patients Council" of Ward 5 North of the New York State Psychiatric Institute.

ARTICLE II—Object

The object of the organization will be to promote the unity of the patients in order to improve environmental conditions and to improve interpatient and hospital staff-patient relationships, thereby providing the

members with an opportunity to accept responsibility for themselves and to gain experience in democratic processes.

ARTICLE III—Membership

All residents of the ward will be considered members and are urged to participate in meetings.

ARTICLE IV—Officers

1. Officers of the council shall be a President, a Vice-President, a Secretary, and a Treasurer.
2. Duties of the officers:
   a) President: The President shall be chief officer and shall preside at all meetings of the council, and perform such duties as are specified according to parlimentary authority, and other duties delegated to him by the council.
   b) Vice-President: In the absence of the President, the Vice-President shall preside and perform the duties of the office of President. The Vice-President shall be ready at all times to render every assistance to the President.
   c) Secretary: The Secretary shall be custodian of the records and keep the minutes of the meetings of the council.
   d) Treasurer: The Treasurer shall keep accounts of all moneys received and expended.
   e) Any officer may be impeached by a ¾ vote of members present after a one week notice of such intent shall have been announced and posted.

ARTICLE V—Liaison with the Administration

An interested member of the staff will serve as Liaison between the council and the administration. Said member of the staff will be invited to meet the council or committee thereof at their discretion, and will also receive copies of the minutes of the meetings of the council.

ARTICLE VI—Elections

1. The four officers will be elected for three months beginning with the first Tuesday in January, April, July and October.
2. If any officer for any reason vacates his office, an election to fill the vacancy will be held at the next meeting.
3. Election will be by secret ballot and a majority of all votes cast shall be necessary to constitute an election.

ARTICLE VII—Meetings

Weekly meetings of the council will be held each Tuesday after nourishment.

ARTICLE VIII—Committees

1. Standing committees: When the council desires that a Standing committee be formed, the President shall appoint a Chairman of the committee,

and the members of the committee shall be appointed by the Chairman. The standing Committee shall consist of:

a) Executive Committee: The four officers of the Council together with the Chairmen of the Standing Committees will meet as the Executive Committee.

b) Social Committee

c) Athletic Committee

2. Temporary Committees: The council may create any temporary committees deemed advisable; they shall be organized by the same procedures as a standing committee. The Chairman of temporary committees may sit with the Executive Committee at the discretion of the President.

ARTICLE IX—Parliamentary Authority

The rules contained in *Roberts' Rules of Order, Revised* shall govern meetings of the council in all cases to which they are applicable and in which they are not inconsistent with these articles.

ARTICLE X—Order of business of Council Meetings

Meeting called to order; reading of minutes of last meeting; report of Treasurer; election of officers; report of Standing and Special Committees; presentation of new members; unfinished business; communications; new business; and meeting adjourned.

ARTICLE XI—Amendments

The constitution may be amended at any meeting by two-thirds vote of the members present after a one week notice of such intent shall have been announced and posted.

Soon after the idea of patient government had been introduced to the patients and the suggestions noted had been forwarded to the administration, one patient on the convalescent floor was noted to be upset, disturbed, erratic in his behavior, negativistic and uncooperative with the spirit of the ward in general. He disobeyed many of the ward rules, often to the point of flouting them, and tended to involve several other patients in this behavior. His periods of rebellious and defiant behavior tended to occur on week-ends; and on different week-ends, he would involve different people in his activities. As a result, the ward administrator felt that ward discipline as a whole had deteriorated markedly, and that in one way or another, the patient group would have to conform more closely to administrative policies. The suggestion was made to the patient-government moderator that this problem be presented *in toto* to the patient council with the idea that they might perhaps find means, through group action, to assist the one group member who seemed to instigate most of the trouble. When this was done,

the patient group refused categorically to accept such a function as part of patient government. They felt that this was an administrative problem and that if the administrative authorities felt that the entire ward should be disciplined, they would accept this discipline but would do nothing to impose disciplinary measures or pressure on their own members.

In view of this feeling, the administrator then proceeded to impose the discipline that he felt was indicated. The patient's week-end privileges were suspended for two weeks. He was then told that he could have full privileges again, but that, if there were any more major infractions of the ward rules, he would be transferred to a floor where there were fewer privileges. He did well on subsequent week-ends, and no further disciplinary measures had to be taken.

Ward discipline, although avoided as a phrase because of its undesirable connotations, nonetheless existed in practice, in administration of the floors to which patients were assigned. The philosophy behind the rules and regulations imposed on patients was that, as they were on a convalescent ward, they were approaching a return to functioning outside the hospital; but, at the same time, they were still patients in a hospital and were, therefore, presumed to need some direction and guidance in daily living. The aims of the administration, then, were (1) to create an atmosphere in the hospital as near as possible to what it would be on the outside in regard to personal freedom and liberty, and (2) to protect the interests, not only of the group as a whole, but also of individual patients who might fall by the wayside under "majority rule." Experience showed further that acting-out tendencies, particularly of the aggressive impulsive nature, were in the main responsibile for conflicts between the administrative staff and individual patients.

In the Psychiatric Institute, much emphasis was placed upon the earning of privileges, and disciplinary action usually involved a suspension of privileges in the area where the unacceptable behavior had occurred. On transfer to the convalescent floor, the patient usually received week-end pass privileges—extending from Friday noon to Sunday evening. Before the patient left on his first pass, the chief nurse explained to him that he was expected to return on time. When a patient was late in returning and did not proffer a reasonable excuse, he was warned by the nurse in

charge that tardiness in the future would result in a loss of privileges. If late a second time, the length of his pass was reduced (usually by 24 hours) by the written order of the ward administrator. If late a third time, he was usually not allowed any pass time on the following week-end. Depending upon the nature of the patient's action and his response toward what was considered fair warning, further repetition was considered a possible indication for transfer back to a more restricted ward. All such disciplinary measures were specifically ordered by the administrative physician, and patients' psychotherapists were not allowed to suspend the orders, or allowed to impose restrictions on their patients. Decisions were made, however, on morning rounds, when the nursing and psychotherapy staff members were present to give whatever information about the patient was relevant to the issue. Thus the therapist was able to separate himself from questions of reward and punishment, and was able to use such "reality incidents" more directly to explore the patients' feelings and attitudes.

Patients were able always to obtain an interview with the ward administrator and were encouraged to do so if they showed that they felt that any suspension of privileges was unjust. Many did not avail themselves of this opportunity; but the administrator considered that more than half of those who did see him had valid objections, and he reduced or suspended his disciplinary orders.

Despite the fact that this system seemed to the administrative staff to be neither harsh nor excessive, it aroused criticism. Patients still had the feeling of an invincible power standing over them, checking on their every move, and this feeling was typically most pronounced in those who had the least reason to be concerned. This attitude, or at least some degree of it, is perhaps essential to any individual who would adjust to community living, and efforts to mitigate it might, therefore, be unwarranted. The present study, in any event, afforded no substitute for it, and the patients as a whole were unwilling to accept self-imposed limitations as part of their group effort.

Later on, however, the intense resistance to self-discipline altered somewhat. There were small moves by certain members of the group in this direction. The need was discussed in meetings with the liaison officer, and further discussion took place within the patient group as a whole. The later felt, not unanimously, that more active co-operation with the staff would not be to their

detriment. Excerpts from the minutes of a patient meeting may serve to illustrate the extent of this feeling. The head nurse had been invited to the meeting. She was chiefly concerned with reacquainting the patient group with certain of the ward rules. "After discussion with the group, Miss M. [nurse] recommended the changing of the meal time slightly in order for the patients to be prompt. Another point Miss M. made was that a person who came late to a meal would receive the course which was being served when he arrived." Other requests for adherence to ward regulations were made by Miss M. "Then Mr. H [patient] asked if the staff was satisfied with the behavior of the patients as a group. Miss M. felt that the behavior in general was quite satisfactory. ... Mr. B. asked if we could get permission to watch the Late Show on the weekend. Miss M. promised to ask Dr. C. [administrator] about it. Mr. K. [patient] inquired about the possibility of sleeping late on week-ends. Miss M. said that the request had already been put to the supervisor and had been denied. But it would be alright to go back to bed on the week-ends after breakfast and chores." The nurse then left the meeting. Other business, concerning funds, was discussed, and the meeting was adjourned. It was clearly evident here that there was adherence to the pattern that involved asking for more and more privileges. Nevertheless, there was also evident a desire on the patients' part to conduct themselves in an acceptable fashion—whatever their motivations may have been.

Results

Individual therapists, for the most part, felt little concern about patient government, saying that they had noted little in their patients as a result of the trial, and that the patients themselves did not ordinarily introduce the subject into their therapy sessions. The few therapists who did note changes emphasized their limited extent. One, for example, wrote as follows, after the program had been in effect for several months:

"The patient learned by himself how to participate in a group undertaking, how to function in the role of a leader in some ways, and how to shoulder the responsibility implicit in leadership in any group undertaking. These things were very valuable to the patient and provided him with a constructive learning experience. It is my feeling that the program functions successfully in a limited area: namely, that it provided patients with an opportunity to

assert themselves and obtain certain concessions and have certain of their wishes granted by means of their own action. This occurred, however, in an essentially dependent and giving setting and largely from the agency of a benign and powerful authority figure from whom they gained strength for their activities. The program did not reach the point where individuals or groups of patients felt collective strength derived from themselves nor did the individuals participating in the patient government reach the point where they could assume and sustain any unpleasant responsibility of any activity which involved giving of themselves rather than receiving."

The therapist-moderator felt, after some months of working with the group, that many of the patients had remained passive and dependent, trying often to manipulate the moderator into fighting their battles for them rather than attempting to solve their problems for themselves. As already noted, however, there was some trend beyond this in later months. It was felt that the group leadership largely determined the general attitude of the group. When the officers were more democratic, there seemed to be more spontaneous interest and willingness to make efforts. With an authoritarian leader, however, many members of the group became apathetic, for they felt he would have things his own way regardless of their efforts. This attitude was certainly not an uncommon one whenever the patient came into contact with any form of authority. A more important point can be made, however, when one considers that many of the patients experienced some significant "firsts" in their association with this group. It was the first time some of them had ever assumed leadership of any kind, had felt accepted in a group, or had expressed themselves before a group with any opinion at all. It is conceivable that these experiences could contribute significantly to the patients' movement toward health.

The ward administrator outlined his evaluation of the trial in a memorandum:

1. Patients

Aggressive patients took the lead. This did not lead to group participation. As was the case on the outside, the passive types were ignored and passed over. It became a manipulative group, seeking to change routines for their benefit with little regard to the need of the institution to exercise control and surveillance. Patients carefully avoided any responsibility in

the area of discipline, and no group pressure was exerted on errant members.

Some of the officers tried to use position to curry extra favors from staff members and to force other patients into doing their ward work for them.

In the beginning, many schizoid patients hoped to use this patient government for a trial of more specific attempts to enter a group; but by the time they might have felt secure enough, they found the group well organized, and organized to a degree beyond their socializing capacities.

There was group regression to the pleasure principle, with less and less evidence of the reality principle as time went on.

There was never any feeling that activities should be geared to help individuals with problems. Instead, the group was of a more coldly calculating type, and it overtly rejected those who could not function at its level.

2. Staff

Some nurses were threatened by attempts of the group to encroach upon their areas of responsibility. Many had felt from the beginning that the patient group would automatically be in opposition, with the result of constant jockeying for favored position with the administrator; and this attitude in itself may have helped to fixate the group on the level at which it eventually became stabilized.

There were very time-consuming and frequent demands by the group, relating to minutiae of ward routine. One felt that this was being used to the fullest as an irritation because the patients had nothing better to do.

In the beginning, there was a tightening of group morale and less administrative restriction; later, there were more administrative restrictions for more serious breaking of rules, such as drinking, breaking restrictions, flaunting late returns from pass.

A few members of the nursing staff were enthusiastic about the potentialities of this experiment. Their attitude was, therefore, not one of fear about the displacement and shifting of responsibilities they considered belonged to them. Rather, they were cordial to the plan and to the patients' overtures—constant "suggestions" which were more in the nature of demands. It was often observed that these nurses were better able to withstand the often obvious attempts at manipulation. They were able to maintain their professional and personal integrity without incurring any serious manifestations of hostility on the part of the patients.

A survey of patients' opinions was made by asking each one to answer a questionnaire. This was after 18 months of the experiment. The questionnaire included the following items: What do

you expect from patient government at the present time? What do you expect from it in the future? How do you feel during the meetings? Describe how you participate in them, with specific examples if possible. Have you noted any changes in yourself, in your goals, or in others as a result of patient government? Are you disappointed in it in any way? Patients were told that they need not sign their names to their answer sheets and that they were not required to fill in the forms. Rather, the trial nature of patient government was explained to them; and it was indicated that their opinions would be of help in assessing its value for future patient groups.

The patients co-operated fully, and most of them signed their names. Their responses revealed a unanimity of favorable opinion. The following are verbatim extracts from completed questionnaires: "... an excellent idea because it gives patients a chance to express themselves and to contribute something towards a group effort, and because it is instrumental in bringing about changes and improvements in certain rules..." "... makes us appreciate the fact that we are considered mature..." "... makes for more efficient and satisfied living on the wards..." "... establishes better relations between patients and staff..." "... makes me feel more worthy as a man..." "... gives the patient social and moral responsibility and prepares him for the outside world... "I have learned to express myself..." "... makes me feel my voice is important..." "I have become more gregarious, more interested in what is going on..." "... it gave me a feeling of belonging..." "... it gave me a feeling of being treated as an adult; no one can be expected to act as an adult if he has never been treated and accepted as one..."

"I feel free to discuss matters openly instead of carrying a gripe..." "... it has helped me to curb my stammering and stuttering, and seeing improvement in others has given me hope for a quicker recovery..." "... it helped me come into full contact with a group in an unselfconscious and effective way..." "... others who are inclined to be withdrawn and uncommunicative are drawn out of themselves..." "... the meetings combat apathy..." "... an opportunity to 'test' myself and my progress in the various areas in which I am troubled..." "... there is not the pressure of 'now or never' that I sometimes feel outside, so I don't feel that anything I say or do at these meetings is final or irrevocable..."

"... qualities of leadership are brought out..." "... patients who are ordinarily taciturn and withdrawn are able to 'come out of themselves' at these meetings, sometimes even to initiate an idea themselves..."

It is interesting that two patients made mention of self-imposed discipline: "I feel that patient government can and will initiate a 'self-enforcement' policy in matters where self-discipline is indicated on the part of the patient. The pressure upon the patient by those he lives with seems to me to be a necessary ingredient in these matters..." And, "I might suggest that the patient government can, as a committee, discipline some of the patients for rules infractions, rather than having such chastisement come from the administration..."

It would appear, then, that patients derived more benefit from patient government than either therapists or the administrative staff realized. This is in line with the observations of Caudill et al.[5] who noted that since patients lacked an adequate channel of communication with the staff, they tended to turn inward and insulate themselves as much as possible from friction with hospital routine.

Conclusions

The following conclusions appear to be justified on the basis of a trial with patient government:

1. Morale is improved in the patients.
2. Co-operation between patients is fostered.
3. Trials at previously-feared behavior are encouraged and fostered.
4. Meetings of the group drain off intragroup and intergroup tensions.
5. With proper guidance, patient government could function effectively as a limited administrative unit.
6. The tendency of therapists is to pay little attention to the lives and behavior of their patients as social units, and to think of them rather as individuals standing alone against a hostile, threatening, rejecting world.

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SECTION 85 OF THE MENTAL HYGIENE LAW*

BY S. C. WOLFF, M.D., AND W. C. JOHNSTON, M.D.

This paper is a brief report on the offenses, stay in Matteawan (N.Y.) State Hospital, and disposition of some 200 patients, sent to that institution as dangerous from the civil state hospitals of the New York State Department of Mental Hygiene, in a period of 23 years. Matteawan is a New York State Department of Correction mental hospital, chiefly for persons charged with crime and found too ill mentally to stand trial or be sentenced, for male petty criminals who become mentally ill while undergoing sentences, and for female convicts of all types who become mentally ill while imprisoned.

When a patient in a civil state hospital becomes dangerous, he also is sent to Matteawan, certified under Section 85 of the Mental Hygiene Law, which replaced Section 83a, formerly governing such transfers, in 1932. There were 204 such patients certified from September 1933 through August 1956, the period covered in this paper.

The title of the pertinent legislation—Section 85—now reads: "Proceedings for certification to Matteawan State Hospital of certain dangerous mentally ill patients of state hospitals in the department." The principal provisions are in Paragraphs 1 and 4; and, because they involve a number of points of interest, they are quoted in full here:

"1. The director of any state hospital, upon order of the commissioner, upon ascertaining that any person, duly certified to and a patient of such hospital as a mentally ill person, has committed or is liable to commit an act or acts which if committed by a sane person would constitute homicide or felonious assault, or is so dangerously mentally ill that his presence in such a hospital is dangerous to the safety of other patients therein, the officers or employees thereof, or to the community, shall forthwith make application to a court of record or judge thereof within the county wherein such state hospital is located or a justice of the supreme court in the judicial district wherein such county is located for the appointment of a commission to determine the dangerous mental illness of such person, and the court may appoint a commission

*From Matteawan State Hospital, Beacon, N. Y. Read before the Dutchess County Psychiatric Society, September 1956.

of not more than three disinterested persons to examine such person and report to the court as to his dangerous mental illness."

"4. If the commission find such a person so dangerously mentally ill that his presence in a state hospital is dangerous to the safety of other patients therein, the officers or employees thereof, or to the community the court if in substantial agreement with the report and opinion of the commission must order that such person be admitted to the Matteawan state hospital, and direct the sheriff to take such person into his custody and deliver him to such Matteawan state hospital and be there confined pursuant to such order, and that upon his mental illness becoming no longer dangerous to safety he may be released as provided in the correction law or he may be transferred to any other hospital in the department upon the order of the commissioner."

Although Paragraph 4 refers to the release of these patients "as provided in the correction law," there actually is no direct reference in the correction law to the discharge of patients com-

Table 1. Hospitals of Origin of Matteawan Patients Certified from Department of Mental Hygiene over 23-Year and 6-Year Periods.

Hospital of Origin	Census Jan. 1, 1956	Sept. 1933 through Aug. 1956	Sept. 1950 through Aug. 1956
Binghamton	3,687	9	2
Brooklyn	4,730	14	3
Buffalo	4,415	9	1
Central Islip	10,646	9	5
Creedmoor	6,843	7	..
Gowanda	3,582	12	1
Harlem Valley	5,807	7	2
Hudson River	6,284	2	1
Kings Park	10,545	29	21
Manhattan	3,618	9	4
Marcy	3,441	10	3
Middletown	3,938	6	1
Pilgrim	15,924	39	13
Rochester	4,447	6	1
Rockland	9,661	16	4
St. Lawrence	2,566	9	1
Utica	2,578	8	5
Willard	3,277	5	3
Totals	105,989	206*	71

*204 patients. Two, returned to civil state hospitals because of faulty certifications, were re-certified later, making 206 admissions.

mitted in accordance with Section 85. The only provision in the correction law for the discharge of patients from Matteawan is in Section 409, which deals specifically with the disposal of insane prisoners after the expiration of terms of imprisonment. It provides that the superintendent of Matteawan may discharge to a relative or friend any patient whose sentence has expired, and who is still insane, but who in the opinion of the superintendent is reasonably safe to be at large.

Table 1 shows admissions to Matteawan from the civil state hospitals over a 23-year period, with hospitals of origin indicated, and total patients on their books shown according to the census of January 1, 1956. Admissions are also shown for the six-year period from 1950 to 1956, to indicate recent trends.

These bare figures represent, of course, a wide variety of personality types and diagnoses among the Matteawan admissions. As an example, Patient A.* represents one of the more unusual admissions under Section 85. This patient was an epileptic who had been admitted to Binghamton State Hospital on a health officer's certificate on December 2, 1933 and was discharged as recovered from a psychotic episode on December 31, 1933. He was re-admitted on a health officer's certificate on May 24, 1934 and was discharged as recovered from this second psychotic episode on June 23, 1934. On October 21, 1934, while living in the community, he killed his wife. He was re-admitted to the civil state hospital for the third time on a health officer's certificate on November 30, 1934 and was certified to Matteawan under Section 85 on March 21, 1935. He is still a resident of that hospital.

*The initials designating the patients are purely arbitrary.

Table 2. Outcome of 206 Certifications from New York Civil State Hospitals.

Outcome	No.
Died	31
Transferred to civil state hospitals	10
Still at Matteawan	140
Returned after original certifications	2
Sent to V. A. hospitals	8
Transferred out of state	4
Discharged to relatives	10
Returned to Kings County*	1
Totals	206

*Indictment pending.

Table 2 represents the status of the Section 85 patients as of September 1956. This table also shows 206 admissions for 204 patients, because of the two faulty certifications. These two patients were returned to their civil state hospital and continued in residence there for several years until they were again considered dangerous and were recertified to Matteawan. One Section 85 patient who was certified to Matteawan as being dangerously mentally ill, also had an indictment pending against him. When he was considered recovered, he was returned to court for disposition of the indictment. Of the 204 patients, 57 were women, and 147 were men.

The ages of admissions for the five years ending with 1956 were reviewed. The youngest patient was 17 and the oldest 78. The mean age was a little more than 32 years. Of the total of 58 admissions during the same five years, 30 were white, and 28 were colored; 53 were native born, and five were foreign born.

Table 3. Causes of Death of Section 85 Patients at Matteawan

Cause	No.
Pulmonary Tuberculosis	4
Disease of cardiovascular system	15
Suicide	3
Epilepsy	2
Nephritis	1
Pneumonia	2
Diabetes	1
Carcinoma	2
CNS Lues	1
Total	31

Table 3 shows the causes of death of the 31 Section 85 patients who died while at Matteawan between 1933 and 1956.

Table 4 shows the diagnoses of the 206 Section 85 admissions. For statistical purposes, paranoid conditions were grouped with the diagnosis of dementia præcox. There were no diagnoses of paranoia.

In comparing the diagnoses shown in Table 4, with those of patients on the books of the civil state hospitals, as shown in the annual report of the New York State Department of Mental Hygiene for 1953, it may be seen that the ratio of patients diagnosed psychosis with psychopathic personality is 10 times higher among

Table 4. Diagnoses of 206 admissions to Matteawan from New York civil state hospitals

Diagnosis	No.
Dementia praecox*	131
Psychosis with psychopathic personality	19
Psychosis with mental deficiency	8
Psychosis with convulsive disorder	21
Alcoholic psychosis	3
Undiagnosed psychosis	1
Psychosis with encephalitis	10
Psychosis with cerebral arteriosclerosis	4
Senile psychosis	1
Psychosis with CNS syphilis	3
Manic-depressive psychosis	2
Involutional psychosis	1
Psychosis due to trauma	2
Total	206

*And paranoid conditions.

the Section 85 cases. The same 10 times higher ratio holds for cases diagnosed psychosis with encephalitis. The ratio is five times higher for psychosis with convulsive disorder, and twice as high for psychosis due to trauma. Mentally defective psychotics are found one and one-half times more frequently than on the books of the civil state hospitals. These findings might have been expected since the organic types mentioned are subject to explosive emotional reactions and outbursts of violence; and since the psychopaths have poor emotional and volitional control and a tendency to anti-social acts. On the other hand, when one compares

Table 5. Basic Reasons for Certification of 306 Admissions to Matteawan

Reason	No.
Murder of an attendant	2
Murder of a visitor	1
Murder of another patient	37
Escape and murder	2
Fracture of skull of attendant	2
Fracture of skull of patient	3
Other assault on employee	84
Other assault on another patient	47
Threats	8
Escape	16
Escape and rape	4
Total	206

the psychoses of the aged, reversed ratios are found—six times as high for this group on the books of the civil state hospitals as among the patients certified to Matteawan under Section 85. This is also to be expected since aged patients have diminished physical capacity, and age lessens aggression. In the other diagnostic categories, there is no appreciable difference in the two groups compared here.

The principal reasons for certification from civil state hospitals to Matteawan under Section 85 are shown in Table 5.

Many patients certified to Matteawan were considered to be dangerous psychotics for multiple reasons. Often they were assaultive, and they also had often attempted to escape from their hospitals. It is interesting to note that escape as a reason for certification to Matteawan under Section 85 was only occasionally mentioned before 1946.

Follow-Up Study

Discharges to Veterans Administration Hospitals

Table 2 shows that eight patients were discharged to Veterans Administration hospitals during the 23-year period under study. Six of these were transferred to the Veterans Administration hospital at Montrose, N. Y., where five still remain. Three of these are under continued treatment with thorazine; one has seizures but is quieter under this medication. The one patient discharged from Montrose is an epileptic who had a psychosis and had been received at Matteawan from Kings Park State Hospital under Section 85. He remained at Matteawan for eight months, and was discharged at the end of five more months of residence at Montrose.

Another transfer to the Veterans Administration was Patient B., received at Matteawan in 1943 from Pilgrim State Hospital, with a diagnosis of dementia praecox, paranoid type. He had had treatment at Pilgrim, where his record showed that he had made a bomb to kill President Roosevelt. He was transferred from Matteawan to the Veterans Administration hospital at North Little Rock, Arkansas on July 7, 1947. He was released on trial visit on January 2, 1948 and was discharged on June 11, 1948.

The eighth transfer to the Veterans Administration was Patient C., admitted to Matteawan in 1950 from Marcy State Hospital with a diagnosis of dementia praecox, paranoid type. At Marcy,

he had struck another patient with a table, and the other patient later died. He was transferred to the Veterans Administration hospital at Canandaigua, N. Y. on March 11, 1953. Following his admission there, his mental condition was unchanged for a time; but after electric shock treatment there, he was placed on a trial visit in May 1954. A recent follow-up by the Canandaigua hospital indicated that he was making a fair adjustment in the community.

Transfers to Hospitals out of State

Four Section 85 patients were transferred from Matteawan to hospitals out of New York state, besides Veterans Administration hospitals; but only two of the four state hospitals concerned replied to letters of inquiry.

Patient D. had been admitted to Matteawan on December 13, 1949 from Pilgrim State Hospital with a diagnosis of psychosis with mental deficiency. He had made several homicidal attacks at Pilgrim. He was transferred to Taft State Hospital in Oklahoma on January 9, 1952. He is still a patient there and shows periods of emotional instability.

Patient E. had been admitted to Matteawan in December 1946 from Kings Park, diagnosed dementia praecox, catatonic type. He had escaped from Kings Park with a hunting knife, and was shot in both legs by a policeman when he was caught. He was transferred to a state hospital in Goldsboro, North Carolina in March 1948 and was released on probation there in April 1948. Soon after his release, however, he was charged with rape and was re-admitted to the Goldsboro hospital in June 1948. He was placed on trial visit in May 1949 and was discharged in June 1950.

Returned to New York Civil State Hospitals

Ten Section 85 patients were transferred to New York civil state hospitals during the 23-year period.

Patient F. had been admitted to Matteawan in March 1953 from Kings Park, diagnosed psychosis with psychopathic personality. He had been one of the ringleaders in an escape in which 17 patients were involved. He was transferred to Rockland State Hospital in September 1954 and in August 1956 was well behaved there.

Patient G. had been admitted to Matteawan from Pilgrim in December 1944, diagnosed dementia præcox, paranoid type. He

continued to be a problem at Matteawan, and a lobotomy was performed. He showed some improvement and was transferred, in August 1950, to Rockland State Hospital where another lobotomy was performed in September 1952. Following this second lobotomy, he developed seizures and was placed on anticonvulsive therapy. The seizures are now under control. He continues to be a problem; he was tried on serpasil with unfavorable results and is now on thorazine, adjusting at a minimal level.

Patient H. had been admitted to Matteawan in March 1942 from Harlem Valley, where he had threatened every employee and physician in the building where he lived. His diagnosis was dementia præcox, catatonic type. He was transferred to Hudson River in August 1942 and, in four months was released to the care of his father. Two years later, he was admitted to Rockland, was placed on convalescent status in a few months, and then was returned to the hospital. He escaped, was re-admitted to Rockland a year later, and was again placed on convalescent status. In May 1956, he was returned to Rockland because of excitement. He was placed on thorazine and continues to be a resident of that hospital.

Patient I. had been admitted to Matteawan in March 1947 from Buffalo, diagnosed psychosis with psychopathic personality. She had been assaultive, and there was a history of an escape. She was subject to fits of impulsive behavior with excitement at Matteawan, but a relative suddenly began to pay regular visits to her there. Her behavior immediately improved. She was transferred to Hudson River State Hospital in May 1956 and was released in convalescent status, in care of her aunt in July 1956.

Patient J. had been received at Matteawan in June 1940 from Kings Park, with a diagnosis of alcoholic psychosis. He had killed another patient with a polisher. He was well-behaved at Matteawan and was transferred to Hudson River State Hospital in January 1947. He was discharged as recovered about eight months later.

Patient K. had been admitted to Matteawan in May 1942 from Middletown, as a case of psychosis with psychopathic personality. He had been emotionally unstable and had attempted to escape. His conduct at Matteawan was good. He was transferred to Hudson River State Hospital in 1944, and was discharged two months later to the custody of his father.

Patient I. had been admitted to Matteawan in 1943 from Middle-

town with a diagnosis of dementia praecox. He had become enamored of a telephone switchboard operator there. He had also made many attempts to escape. His conduct at Matteawan eventually became acceptable; and he was transferred back to Middletown in May 1954, and placed on convalescent care in September 1955. He is adjusting well in the community.

Patient M. had been admitted to Matteawan in October 1953 from Kings Park, diagnosed dementia præcox, hebephrenic type. She had been disturbed, assaultive and had made threats to kill. In June 1955, she was transferred to Creedmoor, and she was released on convalescent care to her mother in November 1955.

Patient N. had been admitted to Matteawan from Brooklyn State Hospital on February 1, 1952 with a diagnosis of dementia præcox. He had developed numerous ideas of persecution, directed against the Brooklyn director. He was well behaved at Matteawan, was transferred to Kings Park in December 1953, and was placed on convalescent care in June 1954.

Patient O. had been admitted to Matteawan in March 1953 from Kings Park, diagnosed psychosis with psychopathic personality. He had been involved in a riot and had attempted to escape. After some time at Matteawan, he became quiet, pleasant and agreeable and was transferred to Creedmoor on January 24, 1956.

Discharged to Care of Relatives

Ten patients were discharged to relatives. Only two relatives, however, answered the letters of inquiry. One patient is apparently well adjusted in the community. The other may be adjusting. The following letter was received in answer to an inquiry about her.

"I am in receipt of your letter of August 22nd inquiring about P. As you know doubt know, at the time of her discharge from the hospital, I was married to her older sister. However, this marriage was terminated in my getting a divorce from her in late 1950 and I have therefore lost contact with the majority of the family. I do know that Mrs. P. moved from Jamestown to somewhere in Maryland or Virginia, and I have heard nothing from her for several years. The last word I had about her is that she married the brother of the fellow her sister left my abode with, therefore, I trust that is a somewhat cozy combination. Outside of that, I am sorry to say that I am not able to supply

you with any further information as I know neither her present address or family status."

Evaluation of 140 Patients Still at Matteawan

An attempt was made to evaluate the remaining 140 patients who are still resident in Matteawan. Fifty-two of them are being cared for on seclusion wards; 69 are on close supervision wards; 19 are on minimal supervision wards. Of the full 140, there are possibly 38 who are well enough behaved to be cared for in a civil hospital with minimal supervision. Many others are deteriorated and will require total care for the rest of their lives.

There are now eight Section 85 patients at Matteawan who are not dangerous and may possibly be well enough mentally for transfer to a civil state hospital, where they might, in a reasonable time, be considered for convalescent status.

Ten patients of the whole group of 140 have been seen by representatives of the Department of Mental Hygiene, and their transfers to civil state hospitals have been disapproved.

Comments

When the number of patients certified to Matteawan under Section 85 was determined, the hospital staff was surprised that the figure was not higher. It is probable that the staff members are more aware of the presence of these patients than of others. One reason for this increased awareness is the inquiries of relatives who frequently ask why a patient has been sent to a hospital for the criminal insane when no crime has been committed. Efforts to explain commitment under Section 85 frequently fail to satisfy a relative.

Another factor that calls attention to the Section 85 patients is the distance of the hospital from their homes and the consequent difficulty for relatives in visiting. Because of this, there are frequent requests for transfers of patients to the civil state hospitals from which they came or to other state hospitals nearer their homes.

A third reason for the staff being more aware of the Section 85 patients is the relative difficulty in releasing them. Since there is no provision for convalescent status at Matteawan, the staff is very reluctant to discharge into the community a patient committed as dangerously insane—without the supervision and obser-

vation given convalescent status patients. Likewise, after patients have shown periods of improved behavior under the closer supervision at Matteawan, their return to civil state hospitals is understandably weighed very carefully by the representatives of the Department of Mental Hygiene who evaluate their conditions and pass judgment on their suitability.

It has been the thought of some members of the Matteawan staff that the disposition of dangerous civil state hospital patients might be made simpler than the procedure under Section 85, which calls for the appointment of a commission. In discussion with some of the Department of Mental Hygiene psychiatrists, the impression has been gained that, on account of the complicated Section 85 procedure, patients who appear to be dangerous are not infrequently kept on their usual wards until more serious behavior develops. If there were some simpler way to solve the problem, dangerous patients might be taken care of before really serious trouble begins.

The only difference between the care and treatment of this group of patients at Matteawan and in the civil state hospitals is that Matteawan provides more strict supervision and greater security. It might be speculated that if one of the civil state hospitals —for example, one in the New York City metropolitan area—had a ward or annex equipped with the same means of supervision and security provided at Matteawan, patients who now are transferred under Section 85 might be sent to such a ward or annex instead. They would remain there until their conditions warranted transfer or release under convalescent care. Such an arrangement need not do away with Section 85, but would be an alternative to it. The metropolitan district is suggested for such a facility because Matteawan statistics show a somewhat larger number of patients from that area than from up-state, and because the metropolitan district hospitals are grouped within a small enough area so that the difficulty of visiting would be less than in an up-state location.

Summary

Two hundred four patients were sent in 23 years to Matteawan State Hospital under Section 85 of the Mental Hygiene Law, after they had been judged to be dangerously mentally ill in the New York civil state hospitals.

Data on these patients are tabulated and discussed here. The discussion covers hospitals of origin, the behavior or acts which led to the transfers, the diagnoses of the patients, and the dispositions so far made of them. There is special reference to some features of particular interest.

The section of the law under which these patients are certified is described and discussed, and suggestions are made for an alternate procedure for handling some of these patients within the Department of Mental Hygiene.

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THE PSYCHO-SOCIAL ADAPTATION OF A FAMILY TO A MENTALLY-RETARDED CHILD*

BY SAMUEL J. BRAUN

The case presented here is reported, not primarily for its interest as a medico-pathological problem, but because it emphasizes the role one member with a chronic disease can play in cementing a family structure, by providing fulfillment of certain needs of other members. It also describes a family "culture" which is reminiscent of a by-gone era. The patient is a slim, 42-year-old woman who displays the classical symptom triad of tuberous sclerosis—adenoma sebaceum, mental deficiency and grand mal epilepsy. The epilepsy was under partial control with dilantin and phenobarbital. There is no family history of such disorder or its specific symptoms. The patient entered Syracuse Psychiatric Hospital in a wheel chair. She was restless and moaning loudly.

She was hospitalized at the request of her family who could no longer tolerate her behavior or manage her eating habits. For 27 years, the patient had generally had four or five seizures daily, lasting for one to five minutes each. She was on phenobarbital during this period. However, four months before her hospital admission, the patient began having from 100 to 200 seizures daily. After four days, she was taken to Good Shepherd Hospital, Syracuse. She remained there for two weeks with improvement on phenobarbital, dilantin and diamox. She was having one seizure every two hours when she was discharged.

After her return home, she frequently refused to get out of bed when asked to do so. She would cry and scream, complaining that everyone was "against her" and saying she wanted to kill herself. She was afraid, however, that she would die, and afraid that no one liked her. On one occasion she talked of killing herself with a knife.

As she had had no menstrual periods for two years some of her "girlfriends" suggested that she was going through "the change of life."

*This clinical report was initiated in the summer of 1957 during a psychiatric clerkship sponsored by the National Institute of Mental Health, United States Public Health Service and supervised by the Department of Psychiatry at the State University of New York at Syracuse. The paper was presented at the psychiatric staff meeting at the State University of New York at Syracuse on January 23, 1958.

Because of her changed behavior pattern and after her refusal for three weeks to eat any food except milk, her family suggested that they take her to the hospital, where she said she would be "pleased to go."

Plain, "pointed" features and long braided hair are striking components of her appearance. Her speech is high-pitched, squeaky and slow, flavored with frequent shrill giggles. She has never learned to read but can write her name with effort. Most of her time is spent in embroidering, cutting out paper dolls and watching television; yet she is not aware of television program names, channel numbers or how to operate the set. She cleans the house, as she feels impelled to, sometimes with such energy that varnish is worn off the floor by her vigorous rubbing. She brushes clothes with such enthusiasm that she rips them at the seams.

Her seizures, which she has had since the age of two, kept her from going to school, which she attended for only three months. These convulsions also kept her from church. The priest told her that, since she got so excited at church, it would be better if he visited her once a week at home.

The patient generally dislikes having visitors in the house, especially children. She sobs or may become angry with the other members of the family for diverting their attention from her to their guests. She listens to many operatic records at home and says that she may study voice some day to become an opera star.

In Syracuse Psychiatric Hospital she stayed in bed most of the time, complaining of dizziness and the poor care she was receiving. Typical comments suggested auditory hallucination: "I know others are talking about me—they say I'm dumb. My sister is around here in the next room or in the hall. I can hear her talking. When I look for her she hides." The patient was also depressed: "Oh God! Oh God! I wish I would pass away. God will take me away." She ate fairly well in the hospital.

The patient's home is the upper flat of a two-family house in a lower-income-bracket district. There are small plots of lawn, with trees, in front and back. A 1937 Chevrolet sits on blocks in the driveway. Shades are drawn in all the rooms, and there is only dim electric lighting. There is plain wooden furniture in all the rooms; the television set is obtrusive in this setting. The whole flat is neat and clean.

The family history was obtained from the half-sister of the patient. This sister is 70 years old. She dresses neatly in clean, much-worn clothing. She chewed gum through the interview. She appeared much younger than her age. Seldom looking at the interviewer, she mostly stared out of the window of the hospital. She gave the impression that this sister and the patient whom she calls "Girlie," were inseparably one.

The sister describes her mother as an eccentric, old-fashioned German woman, a very young-looking 92-year-old with "peculiar ideas." The mother dislikes work indoors with the exception of cooking, and the sister has always done most of the washing and cleaning. The mother does, however, like working outdoors where she spends much time pulling weeds, planting flowers and cleaning the gutter in front of the house. The mother had obdurately refused in the years past to take care of any of the children when they were ill. She felt that since she herself had not made them ill, she had no reason to take care of them. Consequently this too became the older sister's job.

The father of this older girl had died when she was two years old. As the maternal grandmother thought it a "good idea" for the mother to remarry, they sent word to the "old country" to send over a likely would-be husband. Within a year, the mother had married again.

The new husband was not interested in the family—spending most of his time out of the house, either working or drinking "buckets of beer." He came home only to sleep. The children were afraid of him, and never asked for anything for fear he might hit them. He died of a "tumor" in 1920 at the age of 60.

The family boasted 13 siblings; the older half-sister, and the patient were the only girls. When the children were young, they had played the "usual games together but with no enthusiasm." Gradually most of the family drifted away, leaving two brothers, the patient, the older sister and the mother at home. Some thirty years ago, one brother left for a vacation and failed to return or communicate until he made a visit twenty years later, explaining that he hadn't written because he did not want to worry anyone.

An unmarried brother, 67 years old, has remained at home; he works steadily at a local factory. He is described as quiet, dependable but difficult to understand. Customarily he sits in a rocking chair each night, slowly perusing the newspapers while

puffing his pipe. He usually is found, after having fallen asleep in the chair in the early morning hours of the next day.

Girlie's sister went as far as the eighth grade in school, then had to go to work, besides having to take care of the house—and the children when they were sick. She explains, "It has always been hard, but what can I do." She was always lonely but had one boyfriend during her teens who used to visit for two hours every week with her and her parents. They never kissed. He later married someone else.

Girlie was born while her sister was in her late twenties. It became the sister's job to take care of Girlie as an infant since Girlie began to have convulsions from the age of two. At times it was necessary to stay up all night and spend all day with her. This relationship came to fill the sister's loneliness. For now she had her own doll and playmate; she could dress her, feed her, and braid her hair. In fact she would carry Girlie with her wherever she went even though Girlie could walk. Only the patient's increasing weight kept the sister from continuing to lift her. When Girlie was older they could no longer visit with relatives or attend movies together because Girlie would become too frightened; but she continued to learn to talk, sew, and clean with her sister's guidance.

For many years Girlie and her sister had periodically visited a physician every two months. He became Girlie's "boyfriend," or as Girlie used to say it, "my man." Approximately eight months before her hospital admission, this physician died. On each visit, the doctor had taken "Girlie's" weight, and talked over what she had been eating and doing since the last visit. Girlie looked forward to these appointments with much eagerness. After the doctor's death, Girlie and her sister attempted to visit the older physician's son who had taken over his father's practice. But Girlie was bitterly disappointed and would continually ask, "Why did they take my man away?" Gradually, before her onset of continual seizures, some of the behavior pattern of depression began to show.

Discussion

This is a study of unusual inter-relationships, as influenced by the family culture and the personalities involved. The Spartan-like family surroundings provided a framework in which the family members could play their life roles. Consequently, circumstances controlled the lives of the individuals involved; their personal

concerns seemingly relegated to a secondary position. Communication of thoughts and feelings were minimal within the family circle. This affected the individual members involved by diminishing their opportunities to receive and integrate objects to form adequate working concepts or models of human beings. This also decreased their ability to develop effective behavior patterns in response to, or initiation of, contact with other objects. As a consequence, much behavior was directed on a fantasy level. The family members experienced only limited dealings with objects outside the family.

It is likely that the patient exerted a cohesive influence on the rest of the family unit. She became the object of the fantasies of the other family members. In particular, the sister found in her, a daughter, a playmate, a living "toy." Girlie became an object to which the sister could relate a number of her own desires and concepts of self—so long frustrated by an inability to cope with objects outside the family circle—acting them out through the patient.

The patient, then, gave, as well as received, a relative abundance of human contact, which, in her case, was essential to the attention she required for her limited physical and mental status. She then lived in homeostatic equilibrium with her environment, which included family members and the family physician. His death and the failure to find an adequate substitute for him caused a state of disequilibrium in Girlie's relationship to her environment. The reaction of the other family members to the death of the physician certainly had a decided effect on their subsequent relationship with Girlie. For example, the sister, especially, had no longer an object with whom responsibility for patient-care could be shared. Contributing to the disequilibrium are two other factors: the physiological stress of the menopause and the neurologically-determined poverty of Girlie's ego structure. These stresses evoked behavioral manifestations, in the effort to establish homeostasis again. These manifestations were sufficiently stress-provoking to cause the family to deal with the patient by removing her from the immediate family surroundings. Each family member now had to deal with the permanent or temporary loss of an important object.

The role of the physician in this family's life is representative of a once common medical practice which is becoming increasingly

rare in contemporary times. This case points out the importance the patient and family members vest in a meaningful, interpersonal relationship with the doctor. This is a significant phenomenon, particularly in the case of a physician treating a patient with a chronic disease, and is one of which the physician may not be consciously aware.

Conclusion

Treatment of a chronically-ill patient includes consideration and evaluation of the homeostatic relationship exisiting between the patient, each family member and the physician. The importance of this relationship and of the mutual fulfillment of the needs of each member may often not appear quite so obvious as in the case reported in this paper. Permanent separation of the patient from the family unit may severely disturb the equilibrium of the patient and/or family members, so that each individual may alter his behavior pattern adversely in order to adapt to this change. "Adversely" refers here to behavior in relation to the way each family member perceives it. At least temporary separation of one member from the family was necessary in this case. However, it is necessary to weigh the advantage of "better nursing care" in an institution against the inherent advantages of allowing a patient to remain within the family setting.

Acknowledgment

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TEACHING AND DEVELOPING NURSE-PATIENT RELATIONSHIPS IN A PSYCHIATRIC SETTING*

BY MELVIN PERLMAN, Ph.D., AND LORNA M. BARRELL, R.N.

While the nurse-patient relationship is the most fundamental aspect of psychiatric nursing, it is the most difficult concept to communicate. The affiliate nurse comes into her psychiatric affiliation with many preconceived notions about psychiatric patients. In dealing with these misconceptions and building up an undistorted concept of the nurse-patient relationship and its meanings to both the student and the patient, it has been possible to develop several principles and approaches to psychiatric nursing. These have been evolved through a period of two and one-half years of experience, in attempting to communicate to student nurses about nurse-patient relationships.

The Setting and Structure of the Ward Program

The Veterans Administration Hospital, Downey, Ill., the setting for this experience, is a 2,350-bed, primarily neuropsychiatric, hospital. Student nurses from eight hospitals in Illinois and in Indiana affiliate at Downey for 12 weeks as a part of their three-year nursing education programs. Approximately 250 students affiliate each year. While there are four clinical areas used for this affiliation, each student spends six weeks on each of two of them; one, the male section of the acute intensive treatment service (AITS), and the other, the female section of the AITS.** In each clinical area, two to four patients are assigned to each student for the six-week period. In addition, the students have experiences in functional nursing care. Academic and clinical experience are correlated throughout the entire 12-week affiliation period.

The best way to realize the stated philosophy of the educational program—"to further the affiliate nurse's understanding of interpersonal relations, and to facilitate her own personal growth and development"—appears to be through use of both formal class-

*From the Veterans Administration Hospital, Downey, Ill. The authors are indebted to Dr. Julian H. Pathman, chief, acute section, psychology service and Miss Betty S. Mueller, assistant chief, nursing education of the Downey Veterans Administration Hospital, for their encouragement and helpful criticism during the development of the material reported here and the organization of the manuscript.

**Each section of the AITS has two clinical areas. As classes are staggered at six-week intervals, every class is assigned to one clinical area in each section.

room lectures and integrated experience in ward class. While the regular ward classes with the clinical instructor are devoted to exploration of nursing care problems and to the correlation of lecture materials and clinical experiences, an additional two-hour weekly class, conducted jointly by the clinical instructor and the clinical psychologist, is aimed primarily to further the understanding of nurse-patient relationships. The purpose of this paper is to report in some detail about this latter class, held on the male section of the AITS.

The class is informal; it is concerned with the needs of students in relation to any aspect of their affiliation. While they may bring up topics related to the formal content of their course, the principle focus of the class is on the nurses' relationships to their own patients. It is not difficult, in this class setting, for the clinical instructor and clinical psychologist to introduce a certain element of structure in the teaching, aimed toward the development of sound principles of psychiatric nursing care and the interpersonal process.

It is felt that the establishment of meaningful nurse-patient relationships is part of a developmental process. The problem can best be understood through examination of the sequence of discussions in the ward classes. The first hurdle, which always has to be dealt with, is that of conceptions and misconceptions about neuropsychiatric patients. When the affiliates come to their first assignment, they tend to emphasize the differences between the patients and themselves. They see patients as dangerous, animal-like, uncontrolled, belligerent, childish—in general, "maniacal." These preconceived notions often derive from misinterpretation of events reported by their colleagues, and from early learning through popular media such as fiction, movies, and television. The anxieties and fears stemming from these ideas prevent accurate observation and contribute to further misinterpretation. The problem thus becomes one of not simply learning about psychiatric patients, but more important, of unlearning previous misconceptions and biases.

The first of the ward classes is held during the orientation week, at a time when the affiliates have had minimal direct contact with psychiatric patients. After a brief introduction to explain the purpose of the ward class—in which the clinical instructor and the clinical psychologist explain their roles—the students are asked

to give their personal perceptions of psychiatric patients and say what they expect to experience. Through this process, the affiliates readily see that their anxieties are shared by most of their colleagues. By making a feeling a group phenomenon, they are better able to deal with it. This tends to make the group more cohesive, despite the fact that the students come from different backgrounds and different schools of nursing.

Gradually, as these affiliates express their feelings, they are able to look at the patient more constructively. They can then discuss patients as people with problems. At this point they begin to maximize the similarities between themselves and patients, and see the differences as predominantly differences in degree and not kind. With this realistic conception, they are able to transfer previous nursing knowledge and skills to the care of the psychiatric patient. It is only in actually relating to a psychiatric patient that the student is able to put intellectual awareness into meaningful practice. Having once unlearned her previous misconceptions, she now is faced with the problem of learning new and meaningful approaches to people.

Before the student is able to approach the several types of mental patients, she must have some understanding of the meaning of the nurse-patient relationship. This includes both the meaning of the relationship to the patient and to the student. One of the more valuable tools the writers have found for communication about relationships is Chapter XXI of *The Little Prince,* by Antoine de Saint-Exupéry.* In this chapter, the Little Prince, in search of friends, meets a fox whom he attempts to tame. The fox, in his wisdom, tells the Little Prince how he should be tamed (how a relationship is formed). He explains that regularity of contact is expected and that a relationship is of mutual importance. This story is then used to emphasize the importance of reciprocity in relationships, and to help the students establish an understanding of their roles in the total therapeutic environment.

A student is encouraged to plan her day and plan her contacts with the patients. She knows in advance what commitments she and her patients have for any one day, and is encouraged to divide her time as equitably as possible among all her assigned patients. She is further encouraged to see each patient at a regular hour (when feasible) so that mutual expectations may grow. It is felt

*Translated by Katherine Woods. Harcourt, Brace. New York. 1943. (P. 64.)

that with advance planning of the amount of time to be spent with a patient, there is less likelihood that termination of the contact will be dependent on the vagaries of the interaction—such as cutting short a contact when the patient is not verbal or prolonging one when the patient is verbal (and is possibly manipulating the relationship and the length of the interaction). Once the student is able to accept and utilize a structure of planning, she is able to concentrate on other ramifications of nurse-patient relationships.

Dealing primarily with chronically ill patients, the students often feel they can contribute little toward a patient's progress. Their previous orientation has led them to expect that in most cases good nursing care should be rewarded by tangible evidence of improvement and overt expressions of gratitude. In a six-week period, however, they may see little overt evidence of change in their mental patients. This leads to frustration and feelings of inadequacy as nurses. However, close evaluation of the mutual meaning of the nurse-patient relationship may allow them to see that small changes in the relationship can be as rewarding in this setting as gross changes in other settings. This realization is a help to the student in setting realistic goals for her patients, for her relationships with them, and for herself.

The Goals of the Nurse-Patient Relationship

What is a realistic goal for the student nurse in her six-week relationship with a chronically ill patient? The first step is to acquaint the student with the types of improvement or change she may see in her patients. It is only through recognizing what she sees, that the student nurse can hope to achieve any satisfaction. The relationship is the goal. She must be able to see that when a patient shows evidence of expecting her to be there, she may have begun a relationship. Even overt rejection can be seen to be evidence of some meaningfulness of the relationship to the patient. The student has to come to recognize that words or conversation do not necessarily mean relationship, or on the other hand, that the absence of words does not necessarily mean the lack of a relationship. Words cannot be used as a measure of the relationship. It is the change along the continuum, though minimal over a six-week period, which can be extremely meaningful. If even one student in the group can experience this change and share it

with the group, the significance of the idea can be appreciated by others in the group.

Other evidence of change in the relationship can be even more difficult to perceive. Such things as a smile or other facial expression, a shift in position, a change in the rate of (or a cessation of) a patient's pacing, or even participation in a new activity, can be meaningful. The significance of the relationship to the patient may be evidenced by overt rejection of his assigned student nurse and active seeking of contact with other students. In a sense, through example and suggestion, the rejected student is being asked to broaden her concepts and frame of reference about relationships. Though she does realize that dealing with psychiatric patients is different from her earlier experiences, translation of the meaningfulness of this difference is a gradual process. The clinical instructor, the clinical psychologist and the group offer support to the student as she attempts to integrate and appreciate her changing views.

As experiences multiply, the student is able to gain some satisfactions in her work. She is alerted to the dangers of overinvolvement with any one of her patients, as well as to the danger of overinvestment in the satisfaction she may hope to achieve in her eight-hour day. Either mistake can lead to marked frustration and disappointment. The student is encouraged to seek equal satisfactions from all of her patient-relationships. In addition, she is encouraged to take part in social activities while off duty. These suggested sources of satisfaction are in addition to those the student may obtain from learning and sharing her experiences.

Some of the time in the ward class is devoted to introducing and sharing techniques which may facilitate improved nurse-patient relationships. Most relationships begin with the student actively participating in the routine ward activities engaged in by the patient. In addition, at the outset, she will frequently suggest active participation in a game, such as checkers, pool, or cards. These latter activities, while frequently beneficial during the early stage of the relationship, can prove to be ultimately detrimental unless carefully assessed. It was found that a student who became uncomfortable during an interaction with her patient might escape the attempt to deal with this by immediately suggesting "retreat" to a game. For example, a student had worked with a patient for four weeks and had attained a mutually satisfying relationship

with him. Following a visit with his family, he showed increased anxiety about his stay in the hospital and challenged the student with a question. He said, "If you want to help me as much as you say, why won't you let me out the door?" Being unsure of how to deal with this unexpected turn, the student, after a pause in which she failed to respond to his discomfort, suggested that they play a game of ping-pong (hoping to help him substitute for his immediate needs). An example of this type is a good one with which to emphasize the importance of responding to feelings and not to the content of communication. This distinction, important in all therapeutic approaches, has explicit amplification in the writings and practice of the nondirective school of psychotherapy. The comfortable utilization of this approach or technique is a goal, but the students anticipate difficulty in attaining it. Seeing how easy the achievement seems for someone attuned to this method, as the clinical instructor and the clinical psychologist are, the students depreciate their own ability to become comfortable with it and are reluctant to make attempts with it. The group discussion of examples in which responses to feelings have proved valuable, plus the utilization of role-playing situations in the classroom, contribute to greater comfort in this role. It is at this point in their roles as psychiatric nurses that the "class motto" (We profit most from our mistakes) achieves meaning. Mistakes in nursing care can be dangerous; but, in this setting, the students come to appreciate that once there is a basic acceptance of the patient as a person, the mistakes which may be made in the approach can be viewed primarily as "less adequate means" of furthering patient care rather than detriments to patient care. Mistakes can, with such insight, become learning media.

Approaching The Psychiatric Patient

The student needs direction and guidance in planning her general approach to patients who show varying behavior patterns. Psychiatric textbooks and nursing periodicals have elaborated specific techniques for dealing with nursing care problems. These methods are referred to in the ward classes and in individual conferences with the students, so they do not need to be discussed here. In the writers' experience, several types of behavior patterns have predominated in class discussions; and dealing with them has become an objective on which effort has been strongly focused.

These predominant patterns are those of the manipulating patient, the sexually aggressive patient, the withdrawn patient, the over-dependent patient, and the hostile-rejecting patient. While each of these types requires a special approach, one can illustrate the manner in which efforts to learn are focused, by an example from the ward class.

During the first ward class after meeting her patients, a student nurse reported that she had walked up to one of them and had introduced herself, saying, "Good morning, Mr. Jones. I am Miss Smith. I am going to be your nurse for the next six weeks." Mr. Jones stood up and declared in a loud, indignant voice, "I don't need a nurse. I am not sick! Just leave me alone. I don't want to have anything to do with you! Take care of some of these guys who are really sick." With this, the patient stormed off to the washroom where he remained until after all the students had left the ward for class. The second day, when the student approached Mr. Jones and greeted him verbally, he turned and rushed out of the dayroom. This same pattern continued identically for the next three days.

It is understandable that she was feeling very uncomfortable, rebuffed, and extremely inadequate. In sharing this experience with the group, she was asked what she felt the patient was trying to communicate. Her first reaction was the feeling that she was not wanted and that she was not needed by the patient. The clinical instructor and the clinical psychologist, as well as other members of the group, raised the question as to whether she felt the patient's tirade was directed against her as an individual. It was suggested that perhaps she and the group might consider what would have happened to any other student in the same situation. The group was unanimous in expecting the same thing, along with the identical personal affront.

The group was encouraged to evaluate the interaction in terms of the patient's illness and the feeling behind what he was saying. This re-evaluation was facilitated because the student had read the patient's history and communicated it to the group. The focus of the interaction then was turned on exploration of the *real* meaning behind the patient's words. It was suggested that his words might not have meant, "You are no good," but rather were defensive maneuvers aimed at denying his illness.

Students can accept what seems to be personal rejection as a symptom of illness, and recognize that the patient does need help. This intellectual insight gives the student the armor with which to approach the rejecting patient again.

This student in this case was able to approach her patient consistently and on a regular schedule. She continued to structure her time with the patient by greeting him, and by saying when she left that she would be seeing him the next day. She was able to report that she had noticed several changes. These were gradual and were high-lighted by (a) his no longer leaving the room following her salutation; (b) his pacing path growing successively closer to her; (c) his sitting in an adjacent row of chairs after once leaving her; and (d) his remaining in his chair when she approached. All of these could be seen as indications of increasing acceptance of the student by the patient and as evidence of a growing relationship.

On Monday of the students' last week on this ward, Miss Smith told Mr. Jones that it would be her last week there. The following day, when the patients went to the canteen for their weekly visit, Mr. Jones, without saying a word (he had said nothing to her since the day that they had first met), brought a cup of coffee, placed it in front of Miss Smith and sat at the table with her for the rest of the time at the canteen. When Miss Smith reported this to the ward class the following day, she was able to say that she now *really* knew what the clinical instructor and the clinical psychologist were trying to say in the earlier ward class about the significance of a relationship with a psychiatric patient.

While this example was intended primarily to show the technique of approach to a hostile-rejecting patient, many of the principles involved are applicable to approaching all patients. Consistency in the approach, along with the basic acceptance of the individual, seems to be the most important consideration. Also, working conscientiously and trying to understand the feelings behind all communication can help to avert initial discomfort and misunderstanding. Finding support from the other members of the group, and from the clinical instructor and clinical psychologist, affords encouragement for further growth. With this support, the student is able to look more comfortably and skillfully at herself and the role she plays in any interaction.

Criteria For Modulating the Relationship

Thus far, the discussion has concerned the process involved in undoing previous misconceptions and establishing a relationship. In emphasizing the desirability of mutual goals in the relationship, and stressing the difficulties encountered in forming and developing this relationship, there is an inherent danger. It can happen that, once the original inertia is overcome, the student may have difficulty in knowing what limits can and should be set on the relationship. That is, once she has accepted the patient as a person, she may not know how to differentiate this relationship from other relationships she has experienced.

During her first five weeks, a student has the opportunity to test the general kinds of relationships that may be formed with patients. The ward class deals not only with overcoming problems of rejection, withdrawal, sexual aggressivity, manipulations, and overdependency, but also with problems which may derive from overinvolvement with patients. At times, one finds students interacting with their patients as they would with their friends, to the detriment of their therapeutic goals. Only by making the differences between the nurse-patient relationship and relationships with friends explicit, can the nurse-patient relationship be therapeutic. In the ward class of the sixth week, the clinical instructor and the clinical psychologist structure the discussion on this topic.

Because of the fortunate circumstances of affiliation at the Downey Veterans Administration Hospital, the students in the male section transfer at the end of the sixth week, to a clinical area on the female section of the AITS. The transfer from work with male neuropsychiatric patients to work with female neuropsychiatric patients provides an opportunity to explore the similarities and differences anticipated.

Are there any real differences? It is felt that, aside from the usual cultural stereotypes and sanctions concerning relationships with persons of the same or opposite sex, there are no differences in the character of the nurse-patient relationships in the two areas. The usual stereotypes include heterosexual attractiveness, sanctioned male and female aggressiveness in a relationship, and certain limits and rights. These cannot be discounted in discussing differences in female-male and female-female nurse-patient relationships. If these differences are recognized and accepted, they do

not have to remain the significant differences. If they are not brought into focus and openly accepted, however, the students tend to emphasize these problems to the exclusion of others—ultimately limiting their understanding of the nurse-patient relationship.

When the group is able to accept the idea that there is little significant difference in the female-male and female-female nurse-patient relationship, it is possible to raise the question of the differences between the nurse-patient relationship and the "chum" relationship. The word "chum" is used in the class to characterize and include relationships with colleagues, friends, and relatives —everyday close relationships. The reaction to this problem is frequently one of amazement; the students "had never thought of" this distinction. Once the question is raised, however, in terms of the students' own experiences, they seem willing, and are able, to investigate these differences.

The differences which are high-lighted can be characterized under three headings: (a) temporal factors, (b) focal considerations, and (c) emotional participation features.

The most obvious distinction, and that which enters the group discussion first, is the temporal factor. The students can readily see that, whereas most of their relationships have no point of termination, the nurse-patient relationship in this setting is terminated at the end of the sixth week. Although each nurse was encouraged at the outset to tell her patients that she would be their nurse "for the next six weeks," the implications of this statement were seldom realized. With the coming change in clinical area, this problem becomes paramount, and the student finds the need of resolving it. She finds support in the group process. All the students are facing this problem. They come to realize that there must be no expectation of continuing the relationships and are helped by explicit recognition of the fact that the patients have probably been more conscious of this than the students have been. Many patients have previously undergone this experience in light of the repeated changes of students each six weeks. The students are further supported in handling the feelings that are involved—in attempting to "turn off their feelings like a faucet"—by recognizing that a short-term relationship can be therapeutic. While it is realized that, in this setting, such feelings cannot be completely resolved, it is felt that the student is able, with this

overt recognition, to deal with the problem meaningfully and usually successfully.

The consideration of this temporal factor involves understanding the place of the short-term nurse-patient relationship. A gross recognition of the structural limitations of this relationship can have significance in all nursing settings. It is different in kind from the considerations of focus and emotional participation, insofar as it is a feature "outside" the relationship, rather than "within" actual participation in it. What have been called focus and emotional participation are integral parts of the day-to-day nurse-patient interaction.

The next most frequent distinction recognized, in differentiating the nurse-patient relationship from the "chum" relationship, is the focus of the interaction. In most of our day-to-day relations, there is a mutual exchange of information and feelings. In the nurse-patient relationship, the focus has to be primarily on the patient. As is true in any therapeutic relationship, the "therapist" has to be relatively anonymous. The student is discouraged from discussing matters about herself and her extracurricular activities with her patients. When tension arises in the nurse-patient interaction, the easiest way out for the patient (and sometimes even for the student) is to change the focus of the interaction to the student. She is alerted, therefore, to the ways in which patients may attempt to manipulate the relationship in this direction and to the fact that this change may prove to be antitherapeutic. It can even lead to a destruction of the meaningfulness of the nurse-patient relationship, since the student may lose her identity as a nurse and become a "chum." She, in this eventuality, would no longer be able to recognize, or deal with, emotionally determined distortions which inhere in any professional therapeutic relationship. The patient may react toward the student as though she were his wife, mother, girlfriend, or other significant female figure. Recognizing this possibility and its antitherapeutic elements, the nurse avoids reacting in terms of the distortions, and strives to maintain the patient-centered focus of each interaction. In this way, she maximizes her therapeutic role.

The third distinction between "chum" and nurse-patient relationship, and the one which is most difficult to conceptualize is that involving emotional participation on the part of the student. Usually this distinction is raised by a simple question such as how

students feel about their patients' problems. When this is explored, they are asked to look at their feelings about problems their "chums" may have, and those which patients may have. Two brief situations of role-playing—one dealing with a patient's disappointment in a social situation and the other with a friend's disappointment in a like situation—usually help to clarify the contrast which inheres in the two types of relationships. With this exploration, it is not too difficult to conceptualize the differences along the continuum of participation by defining the two words, "sympathy" and "empathy." It is possible to use these terms as keynotes of the distinction. The students can readily see that in their relationships with their friends, they are most prone to use sympathy; a feeling *with** the individual and his problems. In the nurse-patient relationship, they are more apt to use empathy; a feeling *into* the person and his problems, principally on the intellectual level. This distinction allows for a more objective appraisal of the patients' problems and the students' consequent attainment of the therapeutic role.

The Process and Growth

The processes discussed are those emphasized in the first six weeks of the psychiatric affiliation. When the clinical instructor and the clinical psychologist evaluate the process and the student's growth, the question necessarily arises as to whether it may be more advantageous to begin as is done here, or with a pointed explanation of the differences that inhere in nurse-patient relationships as opposed to other relationships. The writers find that, to utilize this distinction, and facilitate therapeutic activities, the student must experience some emotional investment in her patients. Without undoing her preconceived notions about patients and without, in some way, encouraging participation with patients, there is little likelihood that relationships will be formed.

For students whose training procedure is the reverse of those just discussed, students who spend their first six weeks on the

*In differentiating sympathy and empathy, one cannot be completely accurate if he attempts to encompass the distinction through use of a single word or phrase such as, "feeling *with* the individual." The distinction has broader implications, and is differentiated primarily by the ability of a person to keep himself at an objective distance from the patient and his problems. In sympathy, one is apt to become involved with the intricacies of the problems and "take sides." In empathy, or intellectual identification, one can recognize and understand the feelings, but stay outside of involvement in the problems.

female, instead of the male section of the AITS, the ward classes of the second six weeks are begun with an exploration of the distinctions between nurse-patient and "chum" relationships. It is found that, since these students have been able to gain some satisfaction in their earlier experiences, the transition to dealing with male patients is not so difficult as they anticipate. The remaining ward classes are devoted, as with the first group, to exploration of a deepening understanding of the students' therapeutic role in nurse-patient relationships.

The therapeutic aspect of the nurse-patient relationship has been emphasized, because it is felt that growth and change can take place only in a relationship and not outside of it. In addition, unless the student can form at least one significant relationship with a patient, she is likely to leave her psychiatric affiliation without any satisfactions other than purely intellectual ones. By stimulating the formation and recognition of relationships with patients, the student can achieve not only intellectual growth, but emotional growth and gratification also. Having attained some satisfaction in the psychiatric setting in a difficult relationship, the student is able to apply this growth and understanding in her future relationships with patients and in her own nonprofessional experiences.

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SOME ASPECTS OF THE PERSONALITY OF THE NATIVE-BORN WHITE HOMELESS MAN AS REVEALED BY THE RORSCHACH*

BY BORIS M. LEVINSON, Ph.D.

PROBLEM

As is well known, the homeless man usually lacks the experiences making for personality growth and integration. He is sometimes pitied, is sometimes tolerated, is usually despised, but is never accepted or respected as an equal. An invisible wall separates him from the rest of the community. He lives in a subculture all his own. He does not feel wanted, does not share his joys and sorrows, does not achieve, and has little or no feeling of security. He lives in society but he is not of it. He owns no property and has no shred of status. His basic psychological needs for adequacy and self-esteem are not met. He is continually undergoing a process of self-devaluation. The conditions under which he lives are well-nigh intolerable. He stands alone against the world.

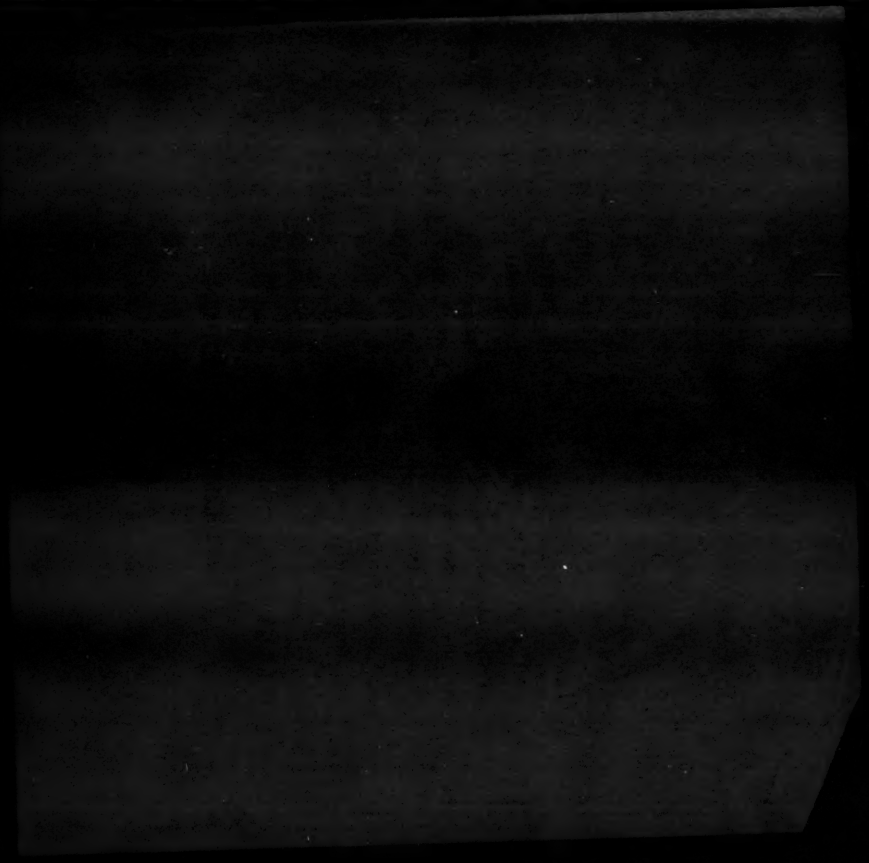
Several questions arise: How can he tolerate such an existence? What mental mechanisms permit him to go on? What are his personality dynamics? Why has he selected homelessness as a solution to his problem and has rejected, so completely, and at such a great personal cost, the customs, traditions, behavior, and moral code of the world from which he came? And finally, what inner controls does he have now?

Certainly, personality problems have brought him to the Bowery.** He can tolerate life in the gutter or in a shelter. Another man, who, on becoming homeless, apparently has similar problems, cannot do so. He seeks another way out, through suicide, or returning to his former mode of life, or becoming mentally ill.

The writer's hypothesis is that the homeless man has always had personality traits differing from known normal or psychiatric groups. Living on the Bowery has exacerbated these traits but did not create them. The possession of the traits has permitted him to continue existing under the usually intolerable state of self-devaluation which exists on the Bowery. Furthermore, the anonymity of life in "hobohemia," the fact that one does not have to socialize or be responsible for himself or for others, is in accord-

*Based on a paper presented at the annual convention of the American Psychological Association, Chicago, September 3, 1956.

**The subjects of this study were Bowery district "derelicts" in New York City.



ance with the psychological picture hypothesized for the homeless man.

Testing Procedure

The present study was carried out at the Men's Shelter of the New York City Department of Welfare in 1955. To eliminate extraneous factors as far as possible, only native-born, white homeless men, most of whom had been on the Bowery for many years, were selected as subjects.

The Rorschach was administered to 50 men who had previously been rated on the WAIS.[1] Some of the men were examined by the writer, but most of them by graduate students* under the writer's immediate supervision. These were students who were in the third year and at the internship level.

The criteria considered to be pathological indicators were:

(*a*) *Loss of reality testing.*

When form was not in agreement with statistically-established general interpretation, the answer was scored F—[2] and considered pathological. Interpretation of a whole on the basis of a part (DW) would also carry a similar connotation. An even more gross distortion—the seeing of something which did not at all correspond to shape—was considered a *perceptual distortion.* These three signs are generally accepted as indicative of a disturbance in thinking and poor ego structure. Generally speaking, these indicators were interpreted here as symptoms of a loss of judgment —caused by the fact that the subject was lonely, had no one to love (was not loved), and was not responsible to any one. It was assumed that this loneliness, in turn, had brought about a regression to primary narcissism.

(*b*) *Contamination.*

Here, too, generally accepted interpretations[2, 3] were followed. When incompatible concepts were fused and located in the same blot area, without the subject's awareness that this response was meaningless, *contamination* was scored.

(*c*) *Fragmentation of the ego.*

Ego fragmentation could be seen in the intrusion into consciousness of somewhat disguised, painful unconscious material. This would result in a record characterized by loss of direction, lack of drive, very little sense of values, and feelings of impotence.

*The writer wishes to express his appreciation to Rabbi Bernard Gelbart, Benjamin Lerner and Lawrence Singer, students who helped administer the test.

(*d*) *Confabulation.*

Whenever the discrepancy was "not so much between the shape of the various blot details and the corresponding part of the concept, but rather between the organization of these parts in the concept and the configuration of the blot material," the concept was scored *confabulation.*[4, p. 226] *b*

The Rorschach protocols were scored in accordance with the Klopfer system.[4] A weight of 1 was given to a main score and of ½ to an additional score. There were very few additional scores; and only the main responses were used in the analysis in this paper. The writer re-scored every test.

The men tested had a mean chronological age of 48.49 with a standard deviation (SD) of 8.30, the range being from 26 to 69. Semi-skilled or unskilled workers made up 88 per cent. Only 12 per cent were either skilled, clerical, or professional workers. Educationally, the median grade achieved was less than the eighth, but 28 per cent had some high school education or had completed high school and 16 per cent either had some college work or had completed college. Occupational status was thus somewhat lower than educational achievement.[5] The mean full scale IQ of the homeless men was 96.79 with an SD of 11.33, and a range from 71 to 124. The mean verbal IQ was 101.30 with an SD of 12.31, and a range from 71 to 133. The mean performance IQ was 91.62 with an SD of 10.90 and a range from 74 to 120. In 43 out of 50 cases, the verbal IQ was higher than the performance IQ.[5]

Results

Only 49 protocols were available for study, as one man refused to take the test. Of these 49, only 40 were submitted to statistical analysis. Nine protocols could not be used because seven men rejected three or more cards and two protocols were invalid due to inadequate inquiry.

Most of the responses were guarded. The inquiry (following the administration) was singularly unrevealing and rarely productive of new concepts. There were perceptual distortions, loss of reality testing, confabulations and contaminated responses.

Table 1 shows the number of cards rejected by the subjects. As one may note, 48 per cent of the homeless men rejected one or more cards.

Table 1. Rejections of Rorschach Cards by Homeless Men N=49

No. of Rejections	No. of Men
1	13
2	4
3	3
4	2
5	0
6	2

Table 2 shows which cards were rejected by the homeless men. The rejections seem to have no relation to the known difficulty of a card or to any of its other properties.[6-8]

Table 2. Rorschach Cards Rejected by Homeless Men N=49

Card Number	No. of Men
1	6
2	5
3	3
4	4
5	3
6	7
7	7
8	2
9	6
10	7

Rejection of cards was interpreted to signify self-rejection. This, it was felt, was brought about by the rejection of the subject by his family. In turn, self-rejection has, in this case, resulted in anxiety and an intrapsychic panic state. To resolve this, the homeless man turns to autistic and dereistic preoccupations.

Table 3 shows the means, SD's, and score ranges, for the Rorschach scores of the native-born homeless men examined for this paper, and a group of normal subjects reported by other investigators.[9] Determinants, and location and content responses which were negligible for the homeless men are not included in this table. It is to be remembered that the homeless men are much older and less educated than the normal group. Furthermore, the group is exclusively male. The normal group consisted of 104 normal adults, 58 men and 46 women. The median age was 34, range 20 to 75. The median education was 12 grades, range 7 to 16.[9] It is of interest to note that the homeless men have much lower scores in

Table 3. Means, SD's and Score Ranges for Rorschach Scores of Native-Born, White, Homeless Men (I) and a Group of Normal Subjects (II)*

	DETERMINANTS							
	M		FM		m			
	I	II	I	II	I	II		
Mean	1.2	3.0	1.1	4.5	0.15	1.0		
Sigma (SD).	1.25	3.1	1.32	3.3	0.38	1.6		
Range	0–5	0–20.5	0–6	1–17.5	0–2	0–13		
	K		F		F%		Fc	
	I	II	1	II	I	II	I	II
Range	0.20	0.2	8.37	9.4	58.20	37.2	0.93	2.6
Sigma	0.97	0.8	4.36	6.9	33.47	16.8	1.01	2.5
Range	0–6	0–3.0	2–19	2–39	12–92	9–84	0–4	0–19
	FC		CF		C			
	I	II	I	II	I	II		
Mean	0.48	2.1	1.2	1.8	0.28	0.2		
Sigma	0.96	2.0	1.38	1.6	0.64	0.5		
Range	0–4	0–7.5	0–6	0–9	0–3	0–3.5		
	W		W%		D		D%	
	I	II	I	II	I	II	I	II
Mean	4.75	9.5	33.03	48	8.3	11.7	57.72	42
Sigma	2.75	4.6	29.90	24	5.74	8.7	12.25	19
Range	0–10	4–28	0–100	12–1	0–27	2–51.5	0–100	7–84
	d		d%		S			
	I	II	I	II	I	II		
Mean	0.78	1.1	4.05	3	0.18	0.9		
Sigma	2.01	2.2	9.7	5	0.55	1.1		
Range	0–10	0–16	0–50	0–25	0–3	0–5.5		
	CONTENT							
	H		Hd		A			
	I	II	I	II	I	II		
Mean	1.38	3.2	0.93	1.2	6.43	9.4		
Sigma	1.42	3.3	1.03	2.0	2.96	4.6		
Range	0–6	0–24.5	0–4	0–10.5	0–15	3–25.5		
	Ad		A+ad%		At		Obj.	
	I	II	I	II	I	II	I	II
Mean	0.8	1.6	48.75	46	0.28	**	1.98	**
Sigma	0.98	2.7	26.99	14	0.53	**	2.40	**
Range	0–4	0–17.5	10–86	26–84	0–3	**	0–10	**

*Normal subjects are from Cass and McReynolds, Ref. 9.

**Data not available on these categories

Table 3. Means, SD's and Score Ranges for Rorschach Scores of Native-Born, White, Homeless Men (I) and a Group of Normal Subjects (II)* (Concluded)

	Bot.		Blood		Nat	
	I	II	I	II	I	II
Mean	1.20	**	0.23	**	0.53	**
Sigma	1.70	**	0.85	**	1.11	**
Range	0–6	**	0–5	**	0–5	**

MISCELLANEOUS

	R		P		Sum C	
	I	II	I	II	I	II
Mean	14.38	24.6	3.43	5.4	1.87	3.1
Sigma	5.75	13.5	1.62	2.0	1.44	2.1
Range	9–33	9–87.5	0–8	2–11	0–7	0–12.5

*Normal subjects are from Cass and McReynolds, Ref. 9.
**Data not available on these categories

determinants, location, content and miscellaneous categories than the normal group.

Table 4 shows the median Rorschach scores of native-born white homeless men as compared to the 50th percentile ranks of a sampling of general population,[9] of adjusted normal young men[10] and of psychiatric patients.[10]

The adjusted normals consisted of 126 males selected by psychiatrists out of a normal population of 151 men who did not have any history of psychiatric illnesses.[10] The median age was 22, range 17 to 36. The median education was 14 grades, the range 8 to over 16. The psychiatric patients were 40 males whose median age was 29, range 18 to 36, median education 12 grades, range 8 to over 16.

While the protocols of the homeless men in this study appear superficially similar to the ones obtained by simple schizophrenics, yet there is a qualitative difference in the homeless men's thinking, and in their reactions, which would seem to indicate that another term more illustrative of their psychopathology is needed to describe their dynamics.

Personality Structure

In reconstructing the personality of the homeless man, as seen through the clues supplied by the Rorschach, one must take into consideration the fact that his dynamics have become obscured by the fragmentation of his ego, the many partially-eroded ego-defenses and the obvious impairment of reality testing.

Table 4. Median Rorschach Scores of Native-Born, White, Homeless Men as Compared to the 50th Percentile Ranks of a Sampling of General Population,* of Adjusted Normal Young Men,** and of Psychiatric Patients**

Rorschach Category	Homeless Men	Cass and McReynolds*	Brockway, Gleser and Ulett** Adjusted Normal	Brockway, Gleser and Ulett** Psychiatric Patients
DETERMINANTS				
M	1.0	2.0	2.0	1.1
FM	1.0	3.5	3.9	3.2
m(m, mF, Fm)	0.0	0.5	1.0	0.9
k	0.0	0.0	0.2	0.8
K(K, KF)	0.0	0.0	0.1	0.1
FK	0.0	0.0	0.2	0.1
F	8.0	7.5	11.5	10.5
F%	58.5	34.0	†	†
Fc	1.0	2.0	1.4	1.0
c	0.0	0.0	0.6	0.2
C′	0.0	1.0	0.8	0.9
FC	0.0	1.5	1.0	0.8
CF	1.0	2.0	2.2	1.6
C, (C, Cn, Csym)	0.0	0.0	0.0	0.1
LOCATION				
W	4.5	9.0	8.4	8.0
W%	37.0	45.0	33.2	30.5
D	8.0	9.5	12.1	10.5
D%	53.0	44.0	48.4	45.5
d	0.0	0.0	‡	‡
d%	0.0	0.0	‡	‡
S	0.0	0.5	2.9	2.9
S%	0.0	‡	10.1	11.8
CONTENT				
H	1.0	2.5	2.6	1.5
Hd	0.5	0.5	1.1	1.6
A	7.0	9.0	9.4	6.7
Ad	0.0	1.0	1.9	0.3
At	0.0	†	2.3	2.1
Obj.	1.0	†	‡	‡
Blood	0.0	†	0.0	0.1
MISCELLANEOUS				
R	12.5	22.5	26.6	22.2
P	4.0	5.5	5.7	5.5
Sum C	1.38	3.0	2.6	1.9

*General population sample from Cass and McReynolds, Ref. 9.

**Adjusted normals and psychiatric patients from Brockway, Gleser and Ulett, Ref. 10.

†Data not available on these categories

‡Not strictly comparable

The writer postulates that the homeless man has had a very poor psychosexual history, as a result of which he has developed a fear of either accepting or sharing affection. At some time, the mother figure had brought about a good deal of ambivalence and anxiety. To love meant to be hurt, to be rejected, to be deserted. He now denies to himself, his need for affection and tends to respond to the demands of the world of reality by repression, by withdrawing into passivity. He, therefore, no longer faces reality, re-fashions it, or re-directs it to satisfy his needs. Because of the poor development of ego, and its fragmentation, his inner controls are also very poor. He, thus, finds it difficult to satisfy his instinctual cravings on a reality basis. However, since he cannot tolerate frustration, he replaces his sadism by masochism. This masochistic layer protects him from further pain, assuages his basically very sensitive ego and insulates him to a very great extent from awareness of his position in the world and his own status in it. Since he replaces activity by passivity, he atones for his guilt (caused by the introjection of society's attitudes) by developing feelings of depression.

In the past, he has found it difficult to empathize with others and accept their ideas and feelings. This difficulty has been a carry-over from his attitudes toward himself and his self-rejection. He now no longer even tries to understand himself and his reactions, and the meeting of people from the past evokes tremendous anxiety. This conflict cannot be resolved by escape into mental illness, as he aborts his anxiety by an excessive consumption of alcohol. Neither is suicide a likely solution, as it would involve too great a mobilization of psychic energy. He, therefore, must flee and change his environment. He has no material resources at this time, no ego strength with which to acquire money or retain it; he fears interpersonal relations; and he is unable to assume responsibility either for others or for himself. The only way out is descent to "hobohemia."

He is able to accept life and to continue existing on the Bowery, because being there is a solution of his problems. His inner productive resources are frozen, and an attempt to change his life and get him to go into a more favorable environment, would provoke conflict, anxiety, and pain. His life on the Bowery is an acting out of his conflicts, an "undoing," an assuaging of guilt, and is a replacement of his phallicism by castration.

Summary and Conclusions

An analysis of the composite Rorschach protocol of 40 homeless men of the Bowery indicates that they are emotionally immature, are depressed, and have great difficulty in adjusting to the world. They lack drive and definite goals, are not adaptable and have feelings of despair and worthlessness. They have very few interests, are apathetic, indifferent and passive. The homeless men feel insecure in relation to their environment, and their social contacts are on a very low level. They lack the ability to empathize, and have difficulty in understanding others, as well as themselves. They show intellectual inefficiency and have thinking disorders. It is hypothesized that being homeless has only exacerbated latent personality trends and that living on the Bowery is the solution of the emotional problems of these men and the natural outcome of the dynamics involved.

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UNDERSTANDING THE AGED*

BY THE REV. NORMAN L. DAVIDSON

The term "aged" is here used to refer to a particular section of the aging process. It does not mean that when a human being arrives at a certain chronological age he automatically fits into the compartment of the aged. Aging is a process which, as has been frequently stated, begins at birth. The rate at which the process develops, biologically and psychologically, varies as widely as there are individual differences in people. Gerontology is a very recent term used for the scientific study of the aging process. Geriatrics refers to the branch of medicine dealing with diseases of the aged. This whole field is a comparatively new area for scientific study. We have textbooks and college courses in the psychology of childhood, of adolescence, and of mature life. These areas of growth, although very extensively interrelated, can be fairly clearly delimited. The area of the aged covers a much larger segment of life. Interest in the subject is showing a remarkable growth. Literature abounds, and articles on research are increasing.

When is a person old? To the small child, 15 years seems old. To the youth of 20, 40 years is old; and at 40, one begins to fear the approach of 50 which seems very old. To hear one's self called "old" for the first time is frequently a devastating psychological experience which has its effect in creating old age. However, individual differences in the rate of aging are such that one person may be old, physically, mentally and emotionally, at 50, and another "young" at 70. This question is still more complex when it is considered that one and the same person may be chronologically 35 years, emotionally 15, mentally 10, and biologically 65. However, in considering the psychology of the aged, one must for practical purposes limit the discussion to the middle and later portions of life.

Nature of Aging Process

To understand a human being, the aging process must be understood. This process has been taken as a matter of course, both by

*Read by the author, then Protestant chaplain of St. Lawrence (N.Y.) State Hospital, before the New York State Mental Hospital chaplains' association in May 1957. Published by arrangement with the *Journal of Pastoral Care* in which it appears in Vol. XII, 17-27, 1958.

physicians and by people in general. Philosophers and poets have discoursed on the subject and there has been a vague academic interest in it. The ancient Greeks held great reverence for their aged seers; but this was due in part to the fact that in those days the very aged were a curiosity because of their rarity. Cicero considered himself an old man in his fifties, and justly so, for few of his contemporaries survived to that ripeness. A young world is interested in youth. It is primarily concerned in exploring the physical universe. It studies about man rather than studies man himself. The early years of growth and development are quick and dramatic; they excite scientific investigation, while the other end of the life's road seems of less moment.

Our culture still attempts to avoid the issue. Age is often feared, shunned and abhorred. By lies and cosmetic subterfuges, men and women try to conceal the signs of age. A sense of shame seems to be associated with advancing years. Why is this? The probable answer is that it is caused by the fear of the loss of social respect. Old age is in ill repute—a feeling transmitted from one generation to another, fostered by youth which wishes to claim the world as its own. This social atmosphere has a devastating effect upon the process of aging and probably has delayed, to a great extent, the more general attainment of what would otherwise be the normal span of life.

The fact is that aging does not mean decline. Senescence, as Stieglitz suggests, is not a downward process. It is change, but not decline. While there are decreases in some capacities, there are increases in others. With waning powers of speed there is often a development of better judgment. There may be a constant maturation of certain capacities, so that, in some respects, gains may exceed losses in the balance sheet of life. At the Institute of Gerontology held at the State University of Iowa in 1953 two conclusions were specific. First, we shall not know how old a man actually is until a great deal more research is completed, and second, our practice of labeling older people "infirm" or "dependent" or "senile" often makes them fit these stereotypes, causing many of them to give up and be bedridden. Such name-calling labels accentuate the greatest fears of the aged; fears of dependency, uselessness, loneliness, and incapacitating sickness.

An important reason for changing the general viewpoint about age is that the aged are now here, and there will be many more

in the years to come. Consider these figures. In 1900 over 3,000,000 persons in the United States were more than 65 years of age. In 1940 there were over 9,000,000. In 1950, more than 11,500,000 persons were over 65, and it is estimated that by 1980 there will be over 22,000,000 of the population above that age. In terms of citizenship, 27 per cent of our voters will be over 65 by 1980. Are these people to be considered a useless drag upon society? Shall we continue with the help of medical science to merely add years to our lives, or by better understanding of the dynamic processes of aging strive to "add life to the years"? The balance of the population-structure has been affected in the past by wars, plagues, famines and other events. But never before in history has the change been in the direction of preponderance of the elderly, as is the case today.

Factors Making for Longevity

In discussing the factors which make for longevity there are two schools of thought. On the one hand, it is said that the only way to insure long life is to choose long-lived ancestors. To determine your own probable span of life merely add the ages, at death of your parents and four grandparents and divide by six. Kallmann and his associates, after studying monozygotic and dizygotic twins, point out that although genetic factors play basic roles, life can be lengthened or shortened within those limits by environmental factors and the efficiency with which constitutional potentialities are utilized. On the other hand, it is argued that many very aged persons have had short-lived ancestors. Kennedy and French hold that living to a great age is largely a matter of nutrition. Others agree that the average age of death at some time in the future can well be expected to be 105 or more. Out of 1,500 known centenarians the Dunbars* selected 20 per cent for detailed case histories. Their average age was 105. The oldest was said to be 125; the oldest whose age was backed with a birth certificate, 115. The Dunbars state that the more we learn about centenarians the more enjoyable becomes the prospect of a life that leads to superlongevity. They concluded their study by giving 10 rules characteristic of the advice of centenarians, as follows:

1. Sleep soundly and regularly.

*From data presented by Flanders and Frances Dunbar at the Second International Geronotological Congress in St. Louis, September 9-14, 1951.

2. Keep out of arguments.
3. Get happily married and stay that way (many of the group had married two or three times).
4. Work all your life at a job you enjoy.
5. Look forward eagerly to the future.
6. Drink or smoke in moderation or abstain.
7. Make lots of friends.
8. Keep alive your sense of humor and your sense of sex.
9. Be your own boss.
10. Do as you please.

It will be noticed that these rules are completely environmental and psychological.

Physical Changes in Aging

Man is now known to be a psychosomatic unity. Any change in one part of the organism will result in the alteration of the total pattern. Knowledge of such changes should aid in preventing premature senility and death. In enumerating a few of the physical changes that are normal in the aging process, one can readily recognize the psychological implications.

For example, consider changes in general appearance. How many adults, upon seeing pictures of themselves at the age of four would recognize themselves? There are differential changes in bulk, in skin and hair. But these normal changes are accentuated by disease, injury, traumatic experiences, and poor mental and physical hygiene. Again, in the aging process, the process of cellular regeneration declines. Some authorities believe that death is inherent in the germ plasm. But others point out that tissue cells transplanted in suitable nutrient media, can be kept alive and vigorous indefinitely. This is given as proof of the essential immortality of the cells. These authorities insist that necrocytosis (cell death) is due solely to the bad effects of an unfavorable environment.

In considering the sense organs, one notes that the eye has a life span as a functioning organ that is potentially greater than that of the body as a whole. In regard to hearing, there is said to be a decline of acuity for tones above high C with each decade of life. Serious impairment of hearing for high tones is more frequent in men; impairment for low frequencies, in women. These facts have a psychological effect upon the aging person and espe-

cially so when his associates are not aware of them and are given to censure or ridicule.

Bones, tendons, ligaments and connective tissue show few characteristic senile changes. The skin, however, is not only very susceptible to physical changes but is very sensitive to moods and emotions. The digestive system, when not affected by disease, is, like the eye, capable of functioning beyond the normal life of the body. This also is said to be true of the liver and gall bladder. The efficiency of the homeostatic mechanisms declines with the years, but the change is not in lessened ability to meet the normal demands of the body. It lies in the lack of reserves for unusual demands. The normal body temperature is the same at 80 as at eight. The difference is in tolerance of extremes.

Behavior Changes

To understand the behavior of the aging person, one must consider the changes in endocrine functioning. Despite considerable research, the nature and working of the various glands is still largely unknown territory. In general, it can be stated that there is a decrease in the output of sex hormones with advancing age, and a decline in copulatory behavior although with wide individual differences. Sexual aging is psychosexual. The climacteric in both men and women is largely influenced by emotional stresses. Stieglitz says that 95 per cent of the women who undergo a normal menopause rarely talk about it while it is in progress. The rest have had previous symptoms of fears and anxieties, which now become aggravated by an unhealthy psychological climate. Some mothers deliberately go out of their way to frighten their daughters with horrors in store for them. Life between 40 and 60 is also associated with peculiar emotional stresses. For most women, this is the time when they lose their children, as they leave home to go out into the world. Husbands also, at this period, may be at the peak of business or professional careers and too absorbed in their own activities to give attention to the family circle. They thus appear to be both disinterested in and neglectful of their wives when the wives need consideration the most.

The climacteric of the male, while more subtle and gradual than that of the female has emotional reactions very similar to those of women. It is characterized by a state of indecisiveness, ready exhaustion, greatly increased irritability, and vague unfocused

anxiety as to future competence. These reactions also depend upon the value which has been placed upon virility and potency. When the individual has found a sense of personal values in other spheres, the loss of sexual potency is not too distressing. But if being virile in the sexual sphere is the one thing he feels proud of, the loss of sexual capacity is likely to be disastrous to the ego. The symptoms may be especially severe if the man faces unemployment at this time.

The writer knows a man who, when his daughter spoke to him about getting married, immediately "blew his top." His behavior was so unusual, so ill-tempered and irrational that the family could not understand what had happened to a good husband and father. They had moved a year previously from a different state because the business to which he had given many years of service had suddenly changed hands; and he, with some others, had been summarily dismissed. The daughter had recently graduated from college and was employed as a teacher. The father had built his own plans for this his youngest child. Now she was about to leave home. The accumulation of misfortunes seemed intolerable. Finally, he was persuaded to visit a physician who gave him hormone tablets, saying that they were vitamin pills. Within a short time, the irreconcilable father and irritable husband became his normal, pleasant self. He called the family together and arranged for the daughter's wedding.

Women's behavior changes may occur at the climacteric because there is no longer fear of pregnancy. The normal drives of the libido need no longer be bridled. Fantasies experienced at adolescence, and more or less sublimated or repressed since, now reappear. Flanders Dunbar* has described many resemblances between the aged and the adolescent. The reactions of aging may be really a re-enactment of psychological puberty. On the one hand, there may be a withdrawal into a beautiful dream world as an escape from the frustrations of life; on the other, an individual may feel compelled to act out long-repressed fantasies, often with embarrassing results to members of the family. Sometimes repressed homosexual conflicts will result in paranoid ideas, and family and social life will be troubled with many jealousies and difficulties. Sometimes these individuals, through wise psychother-

*Discussion by Flanders Dunbar in paper presented by her before the annual meeting of the American Psychiatric Association at Chicago in 1957.

apy, find an emotional adjustment previously unknown. The writer was told by a friend recently of a woman who, some 10 years ago, was having a stormy career in family and social relations. Now she is said to be a much better grandmother than she was a mother.

Intellectual Changes

Factors which make for intellectual change have, of course, great influence upon the behavior of an individual. On the basis of test scores, Wechsler and numerous other psychologists agree that the peak of performance is somewhere in the teens or early twenties and that there is a gradual decline to late maturity. At times, there is a rapid decline in the sixties, but it also appears that, at this age, a plateau in the decline may often be reached and maintained indefinitely—an important matter to remember. Individual differences among aging persons are extremely wide. There are indications that the brightest individuals, on the average, show less decline, both relatively and absolutely, than those who are not so bright. Kaplan observes that the average college graduate at 60 is superior to the average high school graduate at 18.

It is a common observation that the most noticeable decline is in speed. However, there is a difference between the sexes on this point. Women exhibit very little drop in speed between the ages of 20 and 50, whereas men show a progressive loss from decade to decade. It is significant that the average woman at 70 does better in the area of speed than the average male at 20. But it is also of interest, says Kaplan, that male tailors match the performance of women. This emphasizes the fact that experience plays a role in retarding the loss of speed with age. The writer gave a Bellevue-Wechsler intelligence test to a 78-year-old school teacher who had taught him in the first, fourth and eighth grades. Making allowance for speed according to Wechsler's rules, this man scored very superior. Is loss of speed, then, a true sign of old age? There is need of much more research before this can be answered correctly. But even if there is a speed decrement in intellectual tasks does this loss mean a loss of importance to the individual or to society? The most important decisions of life depend upon experience and judgment, not speed. However, the studies of Lorge, Thorndyke and others show that at the age of 80 the average speed of learning is about the same as at 12.

In general, one can say that the learning process may be, and is, greatly retarded by psychological and cultural attitudes. When an individual declares, "I am too old to learn," he is giving himself a death sentence. Educators realize the importance of motivation at any age, and it has an exceptionally important role in the health of the elderly person, although this stimulus is largely lacking for the aged in our society. Premature retirement, or a transfer to sorting nuts and bolts in the junk room, or to gate-watcher is equivalent to a judicial sentence: "You are through and useless." Senescence may be hastened when a man is left on the same job indefinitely. The job doesn't change, the man does. And so the will to live weakens as interest fails; and when the will to live is gone, the science of medicine is pathetically futile.

Education, says Stieglitz, is 50 years behind the times. Education does not prepare us for old age. Curricula are still geared to the time when life expectancy was 15 years less than it is today. The boy or girl is prepared only for the competition of early maturity. After that, "What is the value of living?" When a person is forced to retire, there is no one to depend on him for support. Another takes his place in the home even in the discussion of family needs. He ends where he began, dependent, and now feeling hopeless and forsaken. Both social and educational changes are needed to assure the older person that there are many qualities of the mind, such as judgment, that do not wear out by use. Judgment should improve with age, as learning and understanding develop. Age, per se, of course does not guarantee good judgment. Good judgment grows and develops out of the previous exercise of poor judgment. Greatness of mind in later years comes from continued study which is rarely encouraged for the "average" person.

This discussion has been related to the problem of learning, but one can be more specific. Most people, says Lorge, believe that they ought to give up when they begin to have difficulty in seeing, or hearing. They think that this apparent decline in the senses is associated with decline in the ability to learn. In this they are wrong. Lorge tells of an experiment in which he matched three groups of individuals in learning Russian. One age group was 20 to 25, another 27½ to 37½, another 40 years and older. Several of the oldest group protested that they were too old and that they never were any good at languages. Lorge simply told them, "You

gotta learn it." At the end of two months, there was no significant difference between the three groups. And with the end of the experiment, members of the oldest group said he was unfair to them, because, after such an exciting experience, he had a responsibility to give them more of it. Lillien Martin, founder of the Old Age Counseling Center in San Francisco, tells of an elderly dressmaker who could not remember her own address and got lost in going around a block, but was, nevertheless, able to describe in detail every dress she saw in the windows of the downtown stores. Dr. Martin concludes that most memory loss is due to lack of interest.

Lorge sums up as follows: "We can definitely say as far as the psychologist is concerned; first, that we no longer believe that there is any restriction in intellectual ability. Second, that all these people can and do learn. Third, the primary obstacle is the attitude." The basic problem of therapy, then, is the changing of attitudes. Older persons have a tremendous capacity to utilize experience. They can readjust when they once believe that they can. Also, what they have to readjust with is usually a great deal more than the younger person brings. With the proper psychological development, says Lorge, these people can really be productive in a way that will be of significance to themselves and to society. Research indicates that immeasurable harm is being done by the reiteration of such platitudes as, "You can't teach an old dog new tricks." This is a proven falsehood where the will to learn is retained. It is well here to recall the saying that in order to teach an old dog new tricks it is necessary to know more than the dog.

It is typical of age that past knowledge is integrated and becomes wisdom. Critical judgment improves in the process. The mind becomes quicker to see through the screen of verbiage which is often used to conceal ignorance. In late maturity, there is also a change of stress from the physical to the intellectual as illustrated by the following bit of verse:

King David and King Solomon
Led merry, merry lives,
With many, many lady friends,
And many, many wives;
But when old age crept over them—
With many, many qualms,

King Solomon wrote the Proverbs
And King David wrote the Psalms.

—*James Bill Naylor*

A very familiar, though negative, portrait of old age is given by Horace when he describes his elderly contemporaries:

Gray hairs have many evils, without end
The old man gathers what he dare not spend,
While as for action, do what he will,
'Tis all half-hearted, spiritless and chill;
Inert, irresolute his neck he cranes
Into the future, grumbles and complains,
Extols his own young days with peevish praise,
But rates and censures these degenerate days.

—*Horace*

This is indeed a true picture of many older persons. However, we are becoming aware of the fact that personality patterns are the result of psychological evolution. Personality characteristics developed in youth may become fixed. They may be concealed during the more prosperous years of life. But like the leopard which does not change his spots with age, the traits of adolescence abide —only to reappear. This is not a true second childhood, but only a continuation of first childhood. Emotional maturation is retarded under the pressure of conformity. Now the anxious, insecure, grasping youth becomes the aged stingy miser. The sanctimonious egotist becomes the intolerable, self-opinionated bigot; the perpetual complainer, or the clinging vine, becomes the helpless old person continually demanding attention.

The youth who felt rejected and experienced little love becomes the aged person who rejects children, friends and neighbors. He demands love, but fails to get it because he is at enmity with the world. The psychoneuroses of youth simply become more pronounced with age, because less need is felt to suppress them. On the other hand, the generous become more generous, and the tolerant more liberal and understanding. Witness the good grandmother who has been the happy experience of some of us. Then there are also what Maves calls the occupational hazards which prey upon most of us. The aged physician takes his bedside manner into the living room where he diagnoses all our ills. The schoolteacher gets the habit of lecturing everyone. The preacher talks with authority, as though he were addressing an audience. The

mechanic responds only to a motor. Other characteristics may be labeled "childish." Such are tantrums, peevishness, sulkiness, wheedling. These were hidden under the cloak of politeness when life ran smoothly. With the fears, insecurity and loneliness of age, they reappear. Few persons do mean or childish things consciously, but life situations make adjustment more difficult with age.

For successful aging, certain psychological principles must be observed. Many persons have attempted to set down rules for a happy old age. Several years ago Dr. Harry Moorehouse Gage, former president of Parsons College, Iowa, presented the following.

"1. Learn to play, and don't forget how to play just because you know how to work.

"2. Have an incurable disease and a good annuity.

"3. Build up reserves of (a) physical education; (b) money if possible; (c) knowledge; (d) friendships.

"4. Don't quit as you get older. Start. Live in the present. The aged are specially adapted to take over many of the less strenuous jobs in civic, social, philanthropic and religious activities."

A minister's adolescent son inquired of his aging father, "Why do people, when they reach middle life, so often run out of steam?" To which the father replied: "If we have only steam it gets us somewhere too much. If we have only airbrakes it gets us nowhere at all."

Ireland comes closer to dynamic principles. He stresses: courage as the ability to handle fears; a philosophy of life which gives power to handle grief; patience and a sense of humor. These may not lengthen our years, but they do add greatly to enjoyment. Allied with these qualities, are a sympathetic understanding of people, and a humility which is the opposite of the traits of certain domineering old men and dowagers. Boasting about the past and complaining about the future are equally destructive.

Underlying such admonitions are certain basic psychological laws which must be observed for a successful aging process. Smith, in *The Dynamics of Aging,* mentions seven principles which will be noted briefly.

There is, first, the "persisting continuity of selfhood." This means that the self must grow, and grow toward maturity, if life is to be added to years. Such growth involves increasing ability to see life whole. Many people live in compartments. But with

maturation, the self finds the common dominator of humanity. This so lifts the horizon that life tends to overlap all boundaries of nationality, of family life, of race, color and creed. Life is seen as a pattern, and, for the devout person, at least, it is seen as a pattern with God as the great designer.

Another basic principle lying back of courage, sympathy and a sense of humor is self-perception. This dynamism expresses itself through experience and a richly-furnished mind which projects its joy of living into the outer world. The result is a life rich and full in creative activity.

But if self has continuity, it must not become rigid. Mature growth always involves the ability for change and modification. Proper motivation is also essential here to permit co-operative living, and thus overcome the unpleasant, negative factors in the aging process.

Along with change and modification there must be, in growth, the well-known principle of adaptation. The ego must adapt to the realities of age and, at the same time, distinguish between what is healthful and what is frustrating to itself. Akin to this, is the principle of relinquishment and acquisition. The knowledge of what to let go of, and what to hold onto, is of the essence of an evolving humanity.

The ability to see life whole means also an understanding of time, and/or of the timelessness of life. The maturing life tends to be seen as a continuum, independent of the sentient body. It makes the reality of death seem a trivial matter.

Such knowledge gives a person a sense of harmony with the universe, with the seasons, the weather, the elements, and with all humanity. Humanity itself, in this serene mood, becomes linked with a transcendent world, God's world. We belong to it and are a part of it. This sense of belonging keeps our interests and activities from getting into a rut. There is constant aspiration and search for new things to do. A final principle, perhaps the most important, is that the individual must have a sense of his own worth. Along with this, and the qualities named, he will keep the Vision of Life.

In the keeping of this vision one can, of course, get much help from a wise and intelligent reading of the Bible. And there is much elsewhere. In Tennyson's *Ulysses,* the aged hero speaks to his aged warriors:

The lights begin to twinkle from the rocks;
The long day wanes; the slow moon climbs; the deep
Moans round with many voices.
Come my friends.
'Tis not too late to seek a newer world.
Push off, and sitting well in order smite
The sounding furrows; for my purpose holds
To sail beyond the sunset, and the paths
of all the western stars until I die.
It may be that the gulfs will wash us down;
It may be we shall touch the Happy Isles,
And see the great Achilles, whom we knew.
Tho' much is taken, much abides; and tho'
We are not now that strength which in old days
Moved earth and heaven, that which we are, we are—
One equal temper of heroic hearts,
Made weak by time and fate, but strong in will
To strive, to seek, to find, and not to yield.

But better still are the words which the writer once heard Edwin Markham proclaim from the pulpit of a church when he was over 81 years old.

I am done with the years that are past. I am quits.
I am through with the dead and the old.
They are mines worked out. I have delved in their pits.
I have saved their grain of gold.
Now I turn to the future for wine and bread.
I have bidden the past adieu.
I laugh and lift hands to the years ahead;
Come on I am ready for you.

Perhaps the most wholesome psychology of the aged can be summed up in one sentence: "The past is prelude"—which means, "You ain't seen nothin' yet."

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HOMOSEXUAL BEHAVIOR OF THE INSTITUTIONALIZED DELINQUENT*

BY JACK L. WARD, M.D.

One of the most difficult problems that administrators of institutions for single sexes always face is the homosexual behavior of the inmates. The problem is present in colleges, in boys' and girls' boarding schools, in the armed services and in hospitals. It is of great importance in our penal institutions where it carries the potentials for prison riot or even murder.[1]

The Problem

The correctional official is in a very difficult position. He knows that homosexual activity cannot be stopped. (The author has heard reports that, even in the segregated unit for homosexuals at the Federal Prison's Medical Center at Springfield, Mo. where the patients are kept under close surveillance, 80 per cent of the inmates have asserted that it is possible to have sexual relations with other inmates.) The correctional official also knows that forcible repression and punishment of homosexual behavior only drives it underground, increases the anxiety and explosiveness surrounding it, and denies those who might seek help with the problem access to administrative officials. On the other hand, the prison head knows that the public demands that homosexual practices be "stamped out" and that he may be charged with condoning homosexual behavior if he takes anything but a highly moralistic view of it. It is not strange, then, that wardens and superintendents are reluctant to allow studies on homosexuality in their institutions.** The unfortunate result of this policy is a dearth of scientific literature on the subject. There is, in particular, a lack of investigation into the nature and meaning of homosexual behavior in juvenile institutions.

Some thought has been given to the frequency and meaning of

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**The author believes that a combination of extraordinary prudery and fear of public reaction may have restricted the number and scope of reports in this field. He was once refused permission to publish by a superior officer who objected to the publication of the term "homosexuality," and who remarked that he didn't want his institution identified as "rife with homosexuality." He said, "Not that we should hide it, but people in other institutions 'never' have any homosexuality, and our 'confessing' it will make us the 'only' one with it."

homosexual behavior in adult prisons. For instance Lindner[2] states "... the sex problem in prison is perhaps the most important one of all for inmates and official alike" (p. 454). "As matters now stand sex is unquestionably the most pertinent issue in the inmate's life behind bars" (p. 460). Karpman,[3] in *Sex Life in Prison,* and Devereux and Moss,[4] in their study, speak of the problem as a common one and indict the prison system, as providing conditions under which resort to homosexual behavior is often made unavoidable. Fishman[5] describes how the older "wolf" in prison at first offers the new young inmate protection and favors, only to demand repayment in passive homosexual behavior after the youngster is thoroughly indebted to him. Barnes and Teeters[1] cite the writings of various authors to show the high incidence of homosexual behavior in penal institutions, briefly mentioning the various conditions leading to homosexual practices and calling for reform. However, they do not analyze behavior beyond stating that the prisoners must have sexual outlets.

References to homosexuality in juvenile institutions are even less informative and usually consist of brief notations that homosexual activities are prevalent and represent dangers to normal personality development. One may cite, for instance, Kinsey, Pomeroy and Martin,[6] *Sexual Behavior in the Human Male,* where the subject is treated mainly statistically and then commented on, "Since younger boys have not acquired all the social traditions and taboos on sex, they are more impressionable, more liable to react de novo to any and every situation that they meet. If these adolescent years are spent in an institution where there is little or no opportunity for the boy to develop his individuality, where there is essentially no privacy at any time of day, and where all his companions are other males, his sexual life is very likely to become stamped with the institutional pattern." To find details of the relationships involved in juvenile homosexual behavior, one must have first-hand experience or consult autobiographical material like that in Clifford Shaw's *The Jack Roller,*[7] or material in exposé-type literature, such as Deutsch's, *Our Rejected Children,*[8] where there are brief references to them.

What Does the Behavior Represent?

The homosexual behavior of delinquents has three components stemming from the following three areas: normal adolescent de-

velopment, latent homosexuality, and problems of dependence and self-assertion. The three components are active in every homosexual act in a training school for juvenile delinquents; but their relative strength differs in each case, depending on the circumstances and the individual involved. In some cases one particular component is undoubtedly so predominant that the other two play very minor roles.

The first of the components, normal adolescent development, is based on the fact that in the period of early adolescence there commonly is a certain amount of looking, feeling and experimenting with one's own body and the body of one or more of one's age mates of the same sex. This behavior is probably motivated by curiosity about the physical changes which are occurring at the time and by the newly-awakened sexual drive. This behavior is expected, if not accepted, by most adults and is of no great concern to us here. It might be expected that this motivation would also operate in the case of some delinquents who are 15 or 16 years old, because many of them are retarded in all their relationships to other people as compared to normal children.

The second component, realization of latent homosexual components, is recognized by most authors who mention this subject and is given great importance. Lindner,[2] Karpman,[3] and Kinsey et al.[6] bring this idea into sharp focus. They point out that the prison or training school environment cuts off normal sexual expression and unrealistically expects repression of the normal sexual drive. The inmate is left with his drive in an environment where others are eager to introduce him to the homosexual outlet. If the individual's latent homosexual component is large; and, if he receives considerable gratification, it is likely, especially in the case of the adolescent in his formative years, that his sexual life from then on will be distorted. There is a possibility that the same individual might have been successful in keeping his latent homosexuality repressed and in working out an adequate heterosexual adjustment if he had not been exposed to his experience under confinement. The main objection to these formulations around latent homosexuality is that this component is presented as the most important, if not the sole, source of homosexual behavior. This view ignores the important part that homosexual behavior plays in defining the social role of a boy in a training school society which is organized along a continuum from strength to

weakness. Some of the characteristics of this social system which, in the present writer's opinion, make the third component the most potent in the genesis of homosexual behavior in a training school for delinquent boys, will be described later.

This third component, revolving around problems of dependency and power, is postulated by Devereux and Moss[4] in their study of the Alabama prison system. They write, "Psychoanalytic theory has merely sanctioned in scientific language the general tendency of Western civilization to conceive of intense interpersonal relationships in sexual terms. This statement explains why the prisoner *confuses** sexuality with affective relationships, but does not explain why Western Society does so." The authors outline examples of this confusion and conclude that much prison homosexuality stems from problems revolving around dependency or submission and power or domination. The present paper will attempt to examine this aspect of homosexual behavior in a training school.

Nonsexual Aspects

One does not have to go far into experience to find that questions of domination and submission are thought of in sexual terms. Everyday vulgarities are replete with sexual terminology for events and concepts which are not sexual. For instance, a friend, who is being forced by a person in authority to do something against his will, may howl, "I've been screwed!" If one listens sympathetically, he is likely to hear that the disagreeable gentleman who did this to the friend is a "big prick." In this frame of reference, a psychiatric patient was angrily describing how he had been "reamed out" by his superior who was blocking important parts of a program the patient wanted to institute, and who had attacked the patient's personal integrity, while using his superior rank to prevent adequate defense or counterattack on the part of the patient.

This turn in events had made him feel miserable enough, the patient explained, but to make matters worse he recently had developed hemorrhoids for some unknown reason. He had never had them before. Now he suddenly had almost constant itching and burning, had considerable pain on defecation and even bled slightly. In discussing his two recent misfortunes the patient came to the conclusion that his physical symptoms were exactly those

*Italics, the present writer's.

which he fantasied would be the result if his superior had performed forcible anal intercourse on him. The itching and burning were reduced almost immediately, and the patient was having normal bowel movements without symptoms of hemorrhoids within three days. Another patient complained that, whenever there was any possibility of his being criticized, he experienced an "uneasy feeling" about his buttocks and that he had an almost involuntary contraction of his anal sphincter when he entered his boss's office.

In a series of articles dealing with the concept of pseudo-homosexuality, Ovesey[9-12] breaks down anxiety about homosexuality, into three components—sexual, dependency and power. He considers that the sexual component is the only one that seeks sexual gratification as its motivational goal and that the dependency and power components seek completely different, non-sexual goals, but make use of the genital organs to achieve them. The author points out that in our culture emphasis falls on success and self-assertion and that this ideal is intimately related to our conventional standards for masculine and feminine sociosexual roles. Masculinity is equated with strength, dominance, superiority and success; femininity is equated with weakness, submissiveness, inferiority and failure. Thus the man who fails to meet success goals in any area of behavior is plagued with doubts about his masculinity. Unconsciously his failure may be extended through the following equation: "I am a failure=I am castrated=I am not a man=I am a woman=I am a homosexual."

Ovesey cites many examples from his experiences with patients who suffer anxiety over the idea that they may be homosexual. The dream and fantasy material from these patients shows clearly that dependence is often interpreted as helpless submission to sexual assault and that power is frequently thought of as subjugating another individual to sexual assault. The author concludes, "The great majority of so-called homosexual anxieties are motivated by strivings for dependency and power. These anxieties, as has been shown, stem from pseudohomosexual fantasies that are misinterpreted by the patient as being evidences of frank homosexuality. In reality, the sexual component, if present at all, is very much in abeyance."

The Delinquent and His Environment

Whatever else he is, the adolescent delinquent is an adolescent

and shares the problems of the normal adolescent. He must deal with the awakening of his sexual drive, with a rapidly changing body demanding a rapid change of body image, and with social demands to operate according to adult standards with simultaneous denial of adult privileges; in short, he must live with his confusion as to what he really is and what is expected of him at any one time. When one looks at him in this way some of his hostility toward, and rejection of, adults becomes comprehensible as an exaggeration of the normal pattern. If one further sees him as a rejected child who has experienced traumata during crucial times when he attempted to assume an appropriately dependent role toward important figures in his childhood, one can understand his need to appear tough, self-sufficient, self-centered and without close feeling for others: "Screw them all but six and save them for pallbearers." Why would anyone intentionally assume a dependent position, if his experience has been that this is the best way to get kicked in the teeth?

In a training school for delinquents, the necessity to appear strong and independent is pressing. Institutional living allows no possibility for acceptable withdrawal, for unobserved licking of wounds, for private despair or for undisturbed fantasy. The boys must operate in an atmosphere alive with danger, both real and fancied, from their peers and from institutional authority. Any sign of weakness may be picked up by fellow-inmates and invite attack by another boy who wants to demonstrate his masculine prowess. Institutional authority represents the "cops" or the jailers who are actively engaged in punishing. Their toughness may be emulated. ("Officer Boys" who are chosen to help with routine tasks like conducting cottage residents to the dining hall often outdo the best exponents of top sergeant type behavior among the officers.) But one does not allow one's self to appear weak before the representatives of a persecuting society.

To survive, one must be "the man." Bullying and aggressive homosexual behavior become confused with manliness, while dependence and submission are involved with passive homosexual behavior. The word "punk" is used interchangeably for someone who is dependent, who is afraid to fight, or who is a passive homosexual. Aggressiveness, running away, persecution, demands to be taken care of, and sexual behavior are important subjects of dis-

cussion and cannot be separated one from another, as can be seen in the following group discussion:

Bill's friend Mike is going to be transferred to an institution for older boys. "Seen Mike this morning. Told me he wanted cigarettes and toothpaste. Told Bill too, didn't he Bill? ... Yeah. You got any? You can have them from me. It won't cost you. He shouldn't get shipped. ... No! This is supposed to be a training school. They're supposed to help you. ... If the boys would get together and put enough pressure on the people at the top they could do something about it. At the state school the boys began to run in '49 because of the food—then they got better food."

(Therapist): "Bill where are you in all of this, or are you just too sad to talk about it"?

"He might not get shipped. ... Sure, he will. ... It's easy money. Ship him, one less to take care of. ... Send the boys to C—— and they turn into 'punks.' ... No mother wants her son to come home a 'punk.' She'd rather have him come home all beat up. ... They're supposed to show you a trade. They just give you a test. You ask in school; they won't help you out. They say do it on your own. ... They're men at C——. You ain't got a chance. ... Maybe one of those men might treat you like a son. ... Aw, I heard in P——, they take you for a wife when you come. ... He'll be wrecked in C—— unless he knows someone. Then again maybe he'll probably get along all right. He's got a lot of heart. He's not afraid to fight anybody."

(Therapist to Joe who is vigorously throwing home-made darts into the bulletin board): "You're probably closer to the target than all the rest of us. You think most people want him out?"

"Some do; some don't. Maybe better if he don't. Come on Doc, bring up something for us to talk about. It's dreary."

* * *

It's simple. If someone is strong enough to dominate you, he will force you to submit to him sexually. Your only chance is to fight. If you are really scared you should find someone you can dominate and make him submit to you sexually (there is a pattern of "weak" boys coming into the institution, being forced to be "punks" for others, and then later on becoming "wolves" themselves as they become more experienced). But Mike isn't that scared; he can fight. It's the fault of the adults in the institution. They are sup-

posed to take care of you, but they don't. All you can do is act out your anger by hurling darts into a bulletin board and dropping the hopeless subject.

But this is not a discussion of the fantasies of Ovesey's[10-12] neurotics. These boys are acting-out adolescents. They don't get angry; they throw darts. They don't get anxious; they steal. They don't get frightened; they run or attack. Submission and dependence are not just symbolized sexually in a dream; often there is physical submission in reality.

The following account of the events leading up to a psychotic break demonstrates the importance of problems of dependency and power and their intimate association with homosexual behavior.

Jim, a 17-year-old boy from North Carolina, felt acutely the need to be assertive and self-sufficient. His mother had died before he was a year old. He and his father then went to live with an older woman, Betty, who had reared the father. Jim's childhood memories were relatively happy ones, playing with his father and being affectionately cared for by his "mother" Betty.

When Jim was 10 years old, his father returned from the service, remarried, and abruptly told Jim that Betty was not his mother. The father insisted that Jim live with him and his new wife in another state. Jim protested the move, but was forced to go. He refused to try to get along with his stepmother, blaming her for the separation from Betty. Eventually Jim forced his father to choose between his son and his wife. When the father chose his wife, Jim blamed her for turning his father against him.

Life at home became intolerable for the boy. He became involved in minor delinquencies and ran away at least six times, sometimes trying to return to Betty. His travels took him as far as California, where he was confined for housebreaking in 1954, in an industrial school. Less than a month after he was granted parole, he was committed for auto theft to an Illinois training school. Here he adjusted fairly well. However, his father did not answer his letters and, in May 1955, refused to take him on parole. Betty had died. One of her sons visited Jim, promising to accept him on parole, but he kept failing to return the necessary release papers. In September 1955, while on visit, Jim stole a car. He was arrested and committed to the institution where the writer was stationed.

When interviewed, Jim appeared to be friendly, intelligent and co-operative. He used his considerable verbal facility toward

arousing sympathy because of his family problems. It was the writer's impression that Jim's antisocial behavior was on a neurotic basis and that he would be a good candidate for group therapy. He became one of eight members of a therapy group.* One-and-one-half-hour sessions were held twice weekly.

From the beginning of his group experience, Jim was ambivalent about his aggressive feelings. At first he denied them altogether. For example, he contended that a boy should and could walk away from a fight when challenged by other boys. But at the same time he was loud and verbally aggressive in supporting his opinion against another boy who upheld the idea of standing up and fighting for one's rights. Whenever aggression mounted in the group, as when a boy was accused of being a "punk," Jim immediately would bring up some neutral subject. He frequently introduced women as a general topic of discussion, or he resorted to fantasy.

In earlier sessions Jim appeared to have a warm relationship with a quiet boy named Sam. They were from the same town. When others were silent, they mumbled and talked about home. Jim definitely was dominant, and Sam was content to follow and support him. In the seventh session, Sam said that someone in his cottage had attempted to "frame" him. He implicated another group member in the plot. Jim became hostile toward this boy and told how he had, himself, taken care of someone who had "framed" him. Soon, however, he switched the subject to his fantasy of being the only man on an island of women. He then spoke of Napoleon who, he explained, was killed by his wife who then married her son. The son in turn killed her. The hour ended with another boy's remark that anyone who fooled with Napoleon got his head cut off.

At about the same time in the group process, Jim began to move from his relationship with the more passive Sam to one with a more aggressive and dominant boy named Leroy. Leroy appeared to be strong, according to delinquent standards. He was self-contained, was hostile toward the therapist, and usually spoke only when he had the opportunity to demonstrate his prowess. Though more verbal than Leroy, Jim nevertheless took the submissive role. He joined Leroy in demands for cigarettes from the therapist.

*The writer is indebted to the Rev. Carl Ehrhart for the use of the following material from his therapy group.

He began to verbalize freely concerning himself. At one point he was the leader of a big gang, with others looking up to him; at another he reflected on his childhood, wishing that he could start all over again. The relationship with Leroy became more intimate. Jim laughed loudest at his friend's barbed comments; he supported Leroy's arguments. The two sat in close physical proximity, whispering and laughing at private jokes. In "pig Latin" they plotted to leave the group. However, by the twelfth session it was clear that Leroy had no intention of leaving the group. Jim became somewhat anxious and skipped the next session.

In the following session Jim announced he was going to quit the group because he wanted to spend more time in school. The group was surprised. Sam said, "Who am I going to talk to?" Jack shook his head and said, "Group won't be the same. Why school? You're as smart as me already" (this boy had once called Jim stupid). "I like to argue with you," came from Jim's chief antagonist, Tom. Joe said that he wanted out of group too. He had seen an article on group therapy saying that it was for boys who needed help. "People think the guys in group are crazy." Jim quipped, "They might be right." Joe replied, "I'm not crazy man!" Jack asked him why he listened to the other guys; maybe they were the crazy ones. Tom said that he came to group to get out of work. Sam said that he liked to talk and socialize but was not crazy. "I like the group myself. I'm sticking." Jim accused him of "eating the man" (apple-polishing the therapist).

Leroy challenged, "Why do you want to get out? To work with the women at school?" Sam made a biting sound. Jim laughed and said that Miss A. was not bad. Leroy said he wouldn't get near her because she slaps the boys around. The group then switched to a discussion of how the group could be improved if everyone would reveal his secret thoughts. During this interchange, Leroy and Jim, who were sitting opposite each other, were tapping each other's shoes under the table. Two of the group members seated nearby moved their chairs away. After a long silence, Sam told a story about a man who jumped out of a burning airplane without a parachute only to face uncertainty and great danger on the ground, his only salvation being to find a girl who might not even exist. The group ended with discussion of the more virile type of male movie stars.

The group's initial reaction to Jim's announcement was one of

support. They declared their affection for him. Joe's statement that he wanted out because groups are for crazy people who needed help, touched on the danger of showing dependency needs. The group's immediate denial followed in statements of more acceptable reasons for coming to group. Sam asserted that he could get along in group without Jim. Leroy guessed that Jim was running from the homosexually-loaded group situation to the women in school, and, almost as if to prove his point, started to play footsie under the table with Jim. After the long, uncomfortable silence, Sam made his last attempt to keep Jim in the group with his story suggesting that, while things might be getting hot in the group, running from the group entailed potentially greater dangers.

Two weeks after leaving the group, Jim became involved, as the leader, in a gang homosexual attack on a boy. He was identified as the leader by the four other attackers and by the victim. He was confined to a room. In spite of all evidence to the contrary, he steadfastly maintained that he had had nothing to do with the assault. As his confinement continued, and as it became evident that he would be transferred to an institution for older boys, he became increasingly anxious. On his fifth day of confinement he was observed to rise and stand with his face to the wall. He did not respond to questions, ate nothing and did not urinate or defecate. He held his position without substantial change for 10 hours and then slowly sank to the floor.

When he was examined he was lying on his back with his eyes open and fixed. He held himself in rigorous extension. There was no response to pressure on the eyeballs or to vigorous squeezing of the testes. However, when he saw that his temperature was to be taken rectally, an expression of great terror came over his face, and a spastic contraction of his gluteal muscles made it almost impossible to insert the thermometer. The diagnosis of acute catatonic episode was made, and he was transferred to the psychiatric section of the local city hospital.

In the group session immediately following Jim's psychotic break, the boys were depressed. The quantity of their productions was reduced. The usual arguments and baiting were absent. They talked of how shocked they were, and tried to guess how it had happened. Jim had changed over the past week. He was noisy and was calling attention to himself. Joe said, "It sounds like a neurotic fear. He must have been noisy just to cover up something

else." Tom launched into a description of how transoceanic communications had been fouled up recently by static caused by an explosion on the sun several light years ago. Leroy spent most of the session beating himself on the stomach.

The dynamics of Jim's pathology cannot be traced to his early childhood relationships because information is lacking. However, it is known that when he was 10, he was told abruptly that his mother was dead. He was forcibly separated from his mother-figure, Betty. His father and stepmother rejected him. He was left alone to cope with the tremendous changes of puberty and the problems of adolescence. During this period, parental support is of the utmost importance, as the child's ego is developing adult techniques for handling his own drives and the demands of society.[13] Jim's dependency needs were not met during this period. By the time the writer saw him, he was able to admit his dependency needs only in an intellectual manipulative fashion by using his sad story to elicit sympathy from others. In the group, some of his dependent strivings were pushing close to awareness, and he found himself acting in a dependent manner in relation to Leroy. The passive homosexual implications of this relationship forced him to flee from the group to the women at school.

He found it necessary to act out his manliness in an aggressive homosexual attack that would gain the attention of his peers and of institutional authority. If his object were only a homosexual relationship, he could have availed himself of a covert one, opportunities for which always exist in any large population of institutionalized boys. After he was locked in a room, after the full range of his charm and clever denials failed to move the authorities, and after it became apparent that he would be transferred to a more threatening institution, there was nothing left but submission. But his own unacceptable drives toward submission and the passive sexual implication in submission made a withdrawal from reality preferable, and accounted for the terror on his face and the strong contraction of his gluteal muscles at the approach of the rectal thermometer.

Summary

Homosexual behavior is one of the most important and difficult problems encountered in institutions for juvenile delinquents. Because of the stigma which our society places on homosexuality, and because of society's demand that such behavior be eliminated,

officials are reluctant to encourage investigation of homosexual practices in their institutions; the possibility of unfavorable publicity brings with it the real danger of dismissal from office by public demand. Therefore, there have been few attempts to examine the problem.

The homosexual behavior of institutionalized delinquents stems from three sources; (1) from normal adolescent development, (2) from the realization of latent homosexual components, and (3), most important, from problems of dependency and power. The delinquent characteristically has great dependency needs coupled with fear of trusting, or depending on, adults because he has experienced traumata during crucial times when he has attempted to assume an appropriately dependent role toward important figures in his childhood. This problem area is expressed in the training school social structure, which is oriented along a continuum from strength to weakness. In this setting, strength is equated with independence and power, and weakness is equated with dependence and submission. Bullying and aggressive homosexual behavior are confused with manliness, and dependence and submission are involved with passive homosexual behavior. Delinquent adolescents typically act out their problems rather than internalize them. Much of the homosexual behavior of the institutionalized delinquent represents the acting out of the sexual symbolism of problems of dependency and power that is usually confined to the dream life and fantasy life of adult neurotics. Some examples are given.

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A LONG-TERM PROGNOSTIC CRITERION FOR SCHIZOPHRENICS BASED ON RORSCHACH DATA*

BY ZYGMUNT A. PIOTROWSKI, Ph.D. AND BARRY BRICKLIN, M.A.

Two facts seem to be pertinent to prognosis in schizophrenia. Nearly all large-scale statistical follow-ups, extending over many years, show that about 25 to 30 per cent of schizophrenics eventually improve to such a degree as to be able to live outside the hospital; most of these patients can even support themselves as salaried workers or can function as housewives.[1-4] The decade in which the survey is made, the etiological theories of schizophrenia held by those who treat the patients, the country in which the statistics are collected, and the amount and nature of treatment, do not seem to affect the results.

The remaining 70 to 75 per cent of schizophrenics undergo unfavorable personality changes, severe enough to make it impossible for them to support themselves at any time or to function without close supervision most of the time. The challenging problem is how to tell, during the first examination of the patient shortly after the onset of the manifest psychosis, whether he belongs to the benign minority or to the deteriorating majority. There are clinicians who succeed in making such predictions with a fair degree of accuracy, but this is a rare talent; and no prognostic study of large numbers of patients, based on objective criteria reliably repeatable by others, has reached a high percentage of accuracy. Another matter for consideration is that sudden and great personality changes frequently occur during the first three years after the onset of the manifest psychosis. Striking personality changes are relatively few after the initial period.[5] This generalization has two implications. One is that it may be more difficult to make predictions for the first three-year period than for the second three-year period after the onset of manifest psychosis. The other, positive, implication is that long-term prognoses may turn out to be more valid than short-term prognoses.

A study of insulin-treated schizophrenics indicated that patients who improved after treatment differed from those who did not in

*From the Department of Psychiatry, Jefferson Medical College of Philadelphia. This investigation was supported by a grant from the research committee on schizophrenia of the Supreme Council, 33d degree, Scottish Rite Freemasonry, Northern Masonic Jurisdiction.

a number of traits. The overt behavior and work habits of the patients who improved were disturbed by the anxiety associated with the patients' realization that they were seriously ill. In general, as well as during the Rorschach examination, these patients wasted a great deal of energy, planning poorly, lacking persistence, shifting from one activity to another, and displaying much unorganized activity. When patients were not disturbed by emotional tension and interpersonal relationships, and were rather calm and to the point on the Rorschach test, they failed to improve. Interference of emotional tension with an adequate handling of objective tasks was a necessary but insufficient condition of improvement. The other condition for a guarantee of improvement was lack of noticeable intellectual deficiency. Prognostically, the most favorable combination was a minimum of primary intellectual deficiency with a maximum of overt disturbance caused by anxiety. No improvement could be expected, regardless of the degree of anxiety displayed in overt action, if the primary personality difficulties or intellectual difficulties had reached a certain point. There was no improvement also when the patient showed no subjective disturbing anxiety reaction and seemed to be doing the best he was capable of at the time.[6, 7] On the basis of their experience with lobotomized schizophrenics, Greenblatt and Solomon reached essentially the same conclusion: "The results suggest that two factors, emotional tension and organization of personality, must be considered together in understanding the lobotomy problem. . . . We conceive of lobotomy as being almost specific in reducing emotional tension but having little or no direct effect upon disorganization. A dramatic result may be anticipated only when disorganization is dependent upon excessive emotional tension; in such cases, reduction of tension leads to reintegration, improvement in intellectual functioning and return of capacity to relate to individuals and groups. On the other hand, when disorganization is independent of emotional tension, or exists alone, very poor results may be expected from lobotomy. Fortunately, for the majority of sick patients, emotional tension is a familiar response to the vicissitudes of life, and disorganization more or less a consequence of that tension."[8] Incidentally, Bleuler's old clinical rule[5] that a schizophrenic has a poor prognosis if his consciousness is lucid but his thinking is bizarre and defective has been implicitly confirmed.

There seem, then, to be apparently valid prognostic principles. The trouble seems to be that the application of these principles to individual cases is most difficult. The present investigation is an outgrowth of a previous one which resulted in the setting up of "an experimental criterion for the prognostication of the status of schizophrenics after a three-year interval based on Rorschach data."[9] Two constituents of this experimental criterion, "high evidence" and "intellectual passivity," greatly influence the criterion score in the vast majority of cases, and for this reason are important. It has been found difficult many a time to decide whether a record contained signs of intellectual passivity (which could be briefly described as temporary or permanent loss of the capacity for a critical self-evaluation of the adequacy of one's thinking) or of intellectual flexibility (evidence that the patient evaluated adequately the degree of correspondence between the shape and other physical aspects of his imagined objects and the shape and other physical qualities of the blot areas onto which the images were projected).

There was need for better empirical equivalents (in terms of Rorschach components) of those two traits, intellectual passivity and intellectual flexibility, than those provided by the 1952 criterion.[9] In the new, long-term criterion presented in this paper, more reliable and simpler ways are offered for determining the presence or absence of difficulties in intellectual functioning that are related to prognosis in schizophrenia. The writers assume that a Rorschach component is likely to reflect primary thought difficulties when it deviates in its perceptual and/or conceptual aspects, and when it occurs significantly more frequently in records of schizophrenics who become worse over the years and of patients with demonstrable brain lesions, than in records of schizophrenics who improve with time. This assumption does not necessarily imply that the schizophrenics who get worse (most of them irreversibly) have the same pathology as cerebral organic cases. Similar psychological traits may develop in individuals who differ physiologically or anatomically. Conversely, patients with different psychosomatic symptoms may share the same personality traits. It is now an acknowledged fact there is no close positive correlation between specific psychosomatic illnesses and specific personality traits, as was believed in the past.[10]

The cases reported in this paper were mainly drawn from first-

admission patients to the New York State Psychiatric Institute. A few private patients were also included. The great majority were tested soon after the onset of their psychotic symptoms. Nearly all of the patients were first admissions; about one-third of them had not received any psychiatric care, even on an ambulatory basis, before admission. As a group, the patients could be described as schizophrenics with recent onset of manifest symptoms. At that time, the majority had mild symptoms which did not conspicuously disturb their work or social relations. Additional research with 103 more schizophrenics, completed since this report was first drafted, has shown that the moment in the patient's life, or in his psychosis, at which the Rorschach record is obtained has no effect on the criterion's validity. The new group of 103 patients had a lower average intelligence level than the group described in this report, and it included a large proportion of old cases.

The present report is based on a study of 70 cases: 41 male and 29 female. The average age was 28, with a standard deviation of 8.53. The mean I.Q. was 118, with a standard deviation of 17, as measured by the Bellevue scales. The socio-economic level of these schizophrenics is middle class. The majority of the patients themselves or of their parents were office workers, small shop-owners, and sales personnel. A small minority were professionals with college or university educations. There were no manual workers.

The cases were taken from a group followed up by Lewis and one of the present writers (ZAP). The follow-up status was classified by Lewis[9] as improved, essentially unchanged, and worse—on the basis of personal interviews, anamneses, and reports from physicians and social workers who examined the patients during the follow-up interval. To be placed in the category of improved, or of worse, the patient had to improve or get worse, both in his external adaption (in living or co-operating with others, and in work performance) and in subjective attitude (decrease in anxiety and increase in self-confidence). Three dimensions were involved in evaluating the follow-up status: (1) intellectual impairment, (2) emotional reaction, and (3) social behavior. The final evaluation of a patient was decided on the changes occurring in these three areas. In the few cases where change in one area was incompatible with the kind of change in the other areas, priority was given to indications of intellectual impairment. Intellectual functioning is not so easily and noticeably influenced by the im-

mediate situation as are emotions and social behavior. Therefore, it is a more stable and accurate predictor of behavior in widely different environments in which patients live.

The follow-up diagnoses, not the original ones, were used for the sake of validity.[11] The average follow-up interval was exactly six years with a standard deviation of 3.17 years. First, the records before follow-up of a small group were studied, in order to isolate new relevant prognostic signs. The most discriminating and reliable (easily applicable) criterion signs of the 1952 group were retained. The new set of signs was then applied to previously-scored Rorschach records of 70 schizophrenics whose follow-ups also had been evaluated before this investigation began. The resulting scores were then compared with the follow-up status of the patients. Since available treatment methods alleviate only the secondary effects of schizophrenia (the patients' reactions to their psychosis) and do not remove the underlying cause of schizophrenia, there seems to be no necessity to set up basically different prognostic criteria for treated and for nontreated schizophrenics, especially if the predictions are long-term and treatment is short-term. Some minor modifications may be required if the patient receives appropriate, intensive and prolonged treatment (e.g., psychotherapy).

The Long-Term Scale

The term "scale" is perhaps misleading in the present context. A score of 8 does not imply "twice the deterioration that would be indicated by a score of 4." The scale assesses only the probability of the patient's becoming worse. A score of +2 points or more indicates that the patient most probably will be worse about six years from the time of testing. When a patient functions at a very low level, he cannot get much worse. Thus, in patients who had reached very low levels at the time of testing, the additional worsening at the time of the follow-up was slight.

The specific Rorschach signs which constitute the scale follow.

Sign 1

Sign 1 has the weight of 4 points. To credit the patient with this sign, the sum of M (human movement) must be either 0 or 1, and the sum of weighted color responses must outnumber the sum of M by at least three.

Sign 2

Sign 2 (weighted 3 points): Rpt, or repetition. This sign, frequent in organic cerebral cases,[12] consists of applying the same visual image to at least three different blot areas; at least one of these responses must be of poor form quality. Primary sexual images (genitals) are excluded. The production of such images is prognostically rather favorable in schizophrenia.

Sign 3

Sign 3 (weighted 3 points): vagueness of perception and meaning. The essential feature is the vagueness and tentativeness with which the patient sees the percept (the visual image projected onto a specific blot area) and/or explains its meaning. The percepts that are seen so vaguely are usually simple and popular. In fact, one of the most frequent examples of this sign is this sort of phase: "Could be a butterfly; I don't know; I have no acquaintance with such things" (middle red of Plate III). Sometimes the content of these responses is something that might never have been actually seen by the patient, but is so common in literature, art, entertainment, advertising, etc., that it is extremely unlikely that the patient has never had any sort of visual experience with it. A characteristic feature of Sign 3, is the offering of what appears to be a definite response (more frequently than not of satisfactory form quality) and then bewilderment, if not outright confusion, as the subject vainly tries to add precision to the response.

Just what it is that defies the patient's comprehension, is very difficult to tell. "Resembles some sort of a . . . , does not look like a grasshopper; the top looks like a dragon's head. You cannot make out the size correctly. I don't know exactly what it is. Looks like some sort of dragon" (entire Plate II). "These claws! I don't know what. I see claws. It's something with claws but I can't place it" (top center of IX). "That's a bat with human legs but I'm not sure what the legs belong to or where they go" (whole of VI).

At times, the patient will openly profess being mystified. "Some sort of insect. Looks kind of poisonous. Does not look attractive to the eye. Looks like some frog. I don't know what it looks like exactly. Such things I don't know. I have no acquaintance with them" (gray of III). "Animals climbing. Can pick it out, but not exact enough" (side pinks of VIII). "The beginning of a bat" (whole Plate I); the patient meant that Plate I looked like a

sketchy outline of a bat. "Representing a landscape. Very indefinite, very vague to me" (whole of X). "The beginning of a mouth" (very vague and nondescript small detail of Plate V). "I know it's a bat, but I don't know whether it's there. It can vary a lot," or, "It's mostly a bat" (whole of V). The expression "mostly" is particularly characteristic. "There might be two heads. It's more than that, but I can't continue with this" (top halves of gray in II).

The essential feature of the sign is the vagueness, all the way through additional and close inspection and critical evaluation. It somewhat resembles a weaker manifestation of Plx or perplexity[12] and "a weak hold on a definite form perception."[13]

Sign 4

Sign 4 (weighted 2 points): indeterminate form responses, given with apparent self-confidence. When offering this type of response, the patient seems self-confident, definitely knows what kind of object he "sees," but is indefinite about the visual details of the particular object he talks about. He is sure about the logical meaning of the imagined object, but is either indeterminate or spuriously precise about the perceptible details. Examples: "That's a city but I don't recognize it" (center of plate IX). "That's an animal that I've never seen" (whole of VI). "Might be anything that has a shape" (Plate V, whole). "If not for this (top left detail), it would remind me of a bay and land, and island shapes" (Plate VII). The removal of the left upper third did nothing toward making the plate look more like an island. "I'd say, some formation of land" (Plate VI, reversed). Sometimes it is difficult to decide whether Sign 4 applies, as, for example, when a patient speaks of "designs" or "blotto games" with needless precision which does not make the shape of the imagined object any more definite than it was before the spurious effort at being precise.

In this case, the patient's effort is more than wasted effort or miscarried specification. This is akin to believing that one has actually accomplished something definite and worth while, accompanied by satisfaction that the plate has been successfully interpreted. A similar satisfaction (possible because of very inferior effective self-criticism) can be observed in organic cerebral cases. Prognosis is especially poor when Sign 4 type responses are numerous and the patient shows satisfaction with them and no con-

cern over the inadequacy of his performance. To score Sign 4, it is important: (a) that the blot have some meaning for the patient; (b) that the patient attempt to be precise but succeed only in being spuriously precise; and (c) that he be earnest about these responses. When such responses are given with the deliberate intent to be humorous, they do not qualify as Sign 4.

Sign 5

Sign 5 (weighted 2 points): breakdown of interpretive attitude, resulting in confusion of description with interpretation. This type of reaction is characterized by a fusion of interpretation with unimaginative perception. Examples: "That's a bat, but still an inkblot" (whole of V). "Looking at it sideways, it could be a blot (whole of I). "Some kind of a blot of an insect, isn't it?" (entire I). "It's a butterfly and there is a line in the middle" (whole of I was butterfly; the line was in the vertical middle); the patient was not clear as to whether the line was on the imagined butterfly as well as on the inkblot, or whether the reference to the line was logically (as far as meaning was concerned) independent of the butterfly percept.

To be credited with this sign, the patient has to demonstrate his inability to discriminate clearly and persistently between interpretation in terms of meaningful visual images and mere description in terms of physical qualities.

Sign 6

Sign 6 (weighted 2 points): inappropriate conceptual connection on the basis of a common element. The top gray of X was interpreted as a "windpipe." When questioned during the inquiry, the patient explained, by word and gesture, that he meant the anal-rectal opening. The common element was the idea of a tube for the passage of air or gases; the inappropriateness consisted in treating windpipe and anal sphincter as if their similarities were more important than their differences.

Another patient, looking at plate VII, said: "I believe that it is showing a division, a division of muscles and bones. If not that, a large picture of the Great Divide," meaning the Rocky Mountains dividing two watersheds. Here the shift from bones to watersheds is inappropriate, despite the common idea of division. A third patient first interpreted the thin middle vertical line of Plate I

as a spinal column, and then the entire blot as "bat or rat." While this may have been a clang association, the patient (surprised at being queried about it) explained that a bat and a rat have spinal columns. She "saw" the bat flying with open wings, but the rat "cut open and spread apart."

Sign 7

Sign 7 (weighted 2 points): blurring of difference between imagination and sensation. The patient receives 2 points when at some time during the examination he treats the percept he has offered in interpretation of the inkblot as something in actual existence. It must be clear from the patient's remark that he has forgotten that he himself has produced the percept. The patient may or may not be puzzled. Examples: "Looks like little green worms. I don't think they're alive. I really don't know. It's hard to tell if they're crawling" (top green in X). "I don't know how those musical notes got in" (dots outside of I). "The worms have just gotten up from their chairs. I can't understand why they've gotten up" (bottom green of X).

Sign 8

Sign 8 (weighted 2 points): absurdly inconclusive explanations. This sign consists of the patient's offering matter-of-factly an absurd and inconclusive explanation of at least one of his percepts. The percept itself may be of poor or of good form quality, but it is usually bizarre and rare. The patient co-operates well and tries to think rationally and critically, but fails badly in this attempt. For example, the whole of VII was interpreted as "a lion taken apart." When requested, the patient explained: "If you took this lower part here and put it in the middle, and this part here, well, if this part . . . " The patient went on trying to be clear and rational but getting more and more confused. Another patient interpreted the gray areas and the central white of Plate II as a "throat." To justify this response, he said with simplicity and quiet conviction: "Because it doesn't represent anything else."

Sign 9

Sign 9 (weighted 2 points): absence of human content. Complete absence of human figures in the patient's record adds 2 points to his scale score. Classified as "human content," were images of

whole human figures or parts of them; they might be images of real, historical, or imaginary figures. Anatomical and sexual (genital) percepts are not classified as human content.

Sign 10

Sign 10 (weighted 2 points): F+% below 60. No distinction is made among the F, Fc, and Fc′ responses for the purpose of computing the F+%. If the sum of these three response categories is below 10, the FM can be added to raise the reliability of the F+%.[14]

Sign 11

Sign 11 (weighted 1 point): determinant scarcity. If in the patient's Rorschach record not more than five determinant categories are represented, 1 point is added to his criterion score. There are 11 basic determinants: M, FM, m, c′, Fc′, F, Fc, c, FC, CF, and C. Some of these may appear in combination, e.g., MC, FMC, CFc, Mc′, etc.[14] For the purpose of this scale, each determinant added to the first or main one is counted separately. Thus FMC counts as FM and CF. C added to an M or FM has the weight of 1 point and therefore belongs with the CF, not the FC. However, an additional "c" (as in CFc, Mc) belongs with the "Fc." If the record contains FMc and Fc, it is credited with 2 determinants. It does not matter how many determinants of each type there are; only the number of types counts. Although Sign 11, taken by itself, discriminates well between the improved and worse patients (cf. Table 3), it has the weight of only 1 because it is not so well correlated with the total criterion score as signs 1, 2, or 3.

Sign 12

Sign 12 (weighted 1 point): content monotony. The objects imagined in the responses are classified into various content categories: a (whole animals), ad (parts of animals), h (whole human bodies), hd (parts of humans), at (anatomy or parts of bodies accessible to sight only after an incision), sex (primary and secondary sexual parts), pl (plants or any botanical objects), obj (inanimate objects which can be handled and moved), arch (immovable structures built by humans), maps, la (landscapes), wtr (water of any kind), smb (symbols representing other objects, humans, or human relationships), and so on. Each of these content categories counts as 1. If the patient fails to produce a

content of more than five categories, 1 point is added to his criterion score. Sign 12 also differentiates well, the worse from the improved; but, like Sign 11, its correlation with the total criterion score is not high enough to give it a higher weight than that of 1 point.

Sign 13

Sign 13 (weighted 2 points): no human movement response. "No M" is one of the most reliable single indicators of unfavorable prognosis in schizophrenia and has long been regarded as such. The patient may have both signs 1 and 13; one sign does not exclude the other.

Sign 14

Sign 14 (weighted minus 2 points): at least five human movement responses. This is the only sign with a negative weight, i.e., it is positively associated with improvement. When it appears, 2 points should be subtracted from the patient's criterion score.

Results

A patient's long-term criterion score is the algebraic sum of the weights of the signs found in the patient's record. When the score is below +2, the chances are 18 out of 21 (or 86 out of 100) that the patient will improve; they are 2 out of 21 (or 9 out of 100) that he will remain essentially the same; and they are 1 out of 21 (or 5 out of 100) that he will get worse. When the score is between +2 and +6 inclusively, the chances for improvement are 4 out of 25 (or 16 out of 100); for remaining the same, 5 out of 25 (or 20 out of 100); and for getting worse, 16 out of 25 (or 64 out of 100). When the score is +7 or more, the chances for improvement or for remaining the same are none (according to the present data); for getting worse, on the other hand, they are 24 out of 24 (or 100 out of 100). See Table 1 for details.

When no distinction is made between "same" and "worse" schizophrenics, and when high and low, long-term criterion scores are used to differentiate among the patients—then (as is shown in Table 2) there is a high degree of association between improvement and low scores (of less than +2), on the one hand, and between lack of improvement and high scores (of at least +2), on the other hand. This association is of great statistical significance. The chi-square is 41.03; with one degree of freedom; a chi-square of this size implies that there are practically no chances that such

Table 1. Long-Term Prognostic Criterion Scores For Three Follow-up Subgroups of 70 Schizophrenics

Criterion score	Improved	Same	Worse	Total
—2	8	1	0	9
—1	0	0	0	0
0	9	1	1	11
1	1	0	0	1
2	1	4	4	9
3	0	0	3	3
4	1	1	3	5
5	1	0	1	2
6	1	0	5	6
7	0	0	4	4
8	0	0	6	6
9	0	0	3	3
10	0	0	2	2
11	0	0	4	4
12	0	0	3	3
13	0	0	1	1
14	0	0	1	1
Total	22	7	41	70

a result could be obtained by mere chance ($P<.001$). Of the patients with scores of less than +2, 86 per cent improved, while 92 per cent of patients with scores of at least +2 remained the same or became worse. The cut-off point of +2 yielded the highest degree of differentiation.

Table 3 shows the percentages of patients in each subgroup (improved, same, worse) manifesting each of the 14 signs. The weight given a sign depends not only on how well it discriminates among the subgroups, but also on the kind (positive or negative) and degree of its correlation with the other signs.

To see which prognostic signs were present and which were not, the records were analyzed without knowledge of the patients'

Table 2. Relation of Long-Term Prognostic Criterion Scores to Improvement and Lack of Improvement in 70 Schizophrenics

Criterion score	Improved	Same and Worse	Total
Less than +2	18	3	21
At least +2	4	45	49
Total	22	48	70

Table 3. Percentages of Schizophrenics Within Each Follow-up Subgroup For Each Long-Term Criterion Sign

Sign No.	Sign Description	Percentages Improved	Same	Worse	Total
1	M=O or 1; ΣC—ΣM≷3	—	—	29	17
2	Rpt or repetition	5	—	32	20
3	Vagueness of perception and meaning	5	29	29	21
4	Indeterminate form responses	5	43	24	20
5	Interpretive attitude breakdown	9	—	32	21
6	Inappr. conceptual connection	—	—	5	3
7	Imagin. and sensation blurred	—	—	5	3
8	Inconclusive explanations	—	—	15	9
9	Absence of human content	5	—	24	16
10	F+% below 60	—	14	17	11
11	Determinant scarcity	14	—	56	37
12	Content monotony	9	—	49	31
13	No human movement response	14	—	37	26
14	At least five human movements	50	14	—	17

status after the follow-up. This "blind" application was necessary to guard against conscious or unconscious bias in evaluating the records. If the results are to be repeated, certain conditions must be met: (a) The Rorschach records of the patients must be scored in the same way as were the writers' cases; the scoring criteria are set forth in *Perceptanalysis*.[14] (b) The perceptanalytic prognostic signs must be applied in accordance with the definitions offered in this article. (c) The same criteria of the patients' status on follow-up must be used. (d) The patients must be schizophrenic. (e) The patients must be re-examined after an interval of three to nine years following the Rorschach testing.

The writers cannot and do not claim that their patient population is a truly random sample. There was no attempt at statistical control of differences of sex, age, or intellectual level, because there were not enough cases for this treatment. However, there were no mental defectives. On theoretical grounds one might expect that some mental defectives would obtain high criterion scores because of defective intelligence rather than because of the effects of schizophrenia. On the other hand, it is very probable that the unfavorable significance and the validity of criterion scores above +1 rise with an increase in intellectual endowment. It remains to be seen whether the long-term criterion is helpful with all cases of schizophrenia or only with a special subgroup.

Over two-thirds of the writers' 70 cases were first admissions; they were early cases in the sense that their psychoses had been recognized a year or two before testing. Within the sample, the predictive power of the criterion is as great for the early cases as it is for cases of extended hospitalization or long duration. It is then reasonable to expect that the results of an application of this criterion to a new group of schizophrenics will depend much less on the duration or severity of the manifest psychosis than (a) on the manner in which the Rorschach examination is administered, the data scored, and the signs applied; and (b) on the validity of the psychiatric diagnoses and the evaluation of the follow-up status.

It is generally believed, not without good reason, that it is much more difficult to predict the distant future than the immediate future. It is probably because of this attitude—and the fact that it is so very difficult to predict short-term personality changes of early cases of manifest schizophrenics—that little work has been done with test predictions of long-term changes. One of the observations underlying the present approach is that schizophrenics undergo relatively few radical personality changes after they have been manifestly psychotic for more than three years.[5] The other observation serving as a guide is that, in some respects, Rorschach records of schizophrenics who fail to improve resemble records of patients with intracranial pathology; this is not true of records of schizophrenics who improve over the years.[15] The writers hope that this investigation will shed some light on the problem of differentiation between reversible and irreversible personality changes in schizophrenia.

Summary

1. This article offers a revised long-term prognostic criterion, based on Rorschach data, for prediction of the status of schizophrenics after an interval of from three to nine years. Seventy schizophrenics were followed over an average interval of six years.

2. The criterion scores— applied "blind," i.e., without knowledge of the follow-up status of the patients—correctly placed 90 per

cent of the 70 schizophrenics in these two follow-up categories: (a) improved, and (b) same or worse.

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EDITORIAL COMMENT

ONE-TRACK MAN

This journal has engaged from time to time in speculation about the nature of man, noting, among other things, that how one sees man depends chiefly on one's viewpoint—or in modern scientific jargon, one's frame of reference.

To John Milton or Dante Alighieri, man may be a fallen angel; to Charles Darwin, a proud achievement of nature; to Owen Meredith, who wrote verse, a cook; to Auguste Rodin, who cast man in bronze, a thinker; to many an anthropologist, a fire-user; to many a clergyman, a soul for the saving. This journal recently discussed man as "The Suicidal Animal," the only known living creature capable of purposely ending its own existence.*

It is now purposed to discuss man as he appears in a best-seller by an economist, Galbraith's *The Affluent Society.*** Or, perhaps, to be more specific, what will be chiefly discussed is man of Galbraith's "New Class," a phenomenon the author considers characteristic of our present society of plenty.

The New Class appears to be made up of scientists, educators, writers, clergymen; it includes all the egg-heads. And besides the egg-heads, it includes persons who might be considered their opposite numbers in the ranks of business, industry, the armed services, politics, law and high finance. It includes everybody who shares what Professor Galbraith considers the identifying characteristic of the New Class, work for the sake of real or pretended enjoyment in the work done, instead of for financial gain (which is, to begin with, a sufficiently astonishing finding for an economist and pretty close to an obsessive-compulsive state, a psychiatrist might say).

Most generally-informed persons may be inclined to agree with Galbraith that the New Class he describes is real and is emerging at just about the time a nearly classless society seemed in process of being born. The psychiatrist and psychologist, who have long had views of humanity greatly at variance with the economist's, will take particular interest in Galbraith's single-purposed man of the New Class. This chap will suggest to some of them another

*Editorial: The suicidal animal. PSYCHIAT. QUART., 31:4, 763-778, October 1957.

**Galbraith, John Kenneth: The Affluent Society. Houghton Mifflin. Boston. 1958.

all too-familiar example of the character with one idea—the fellow whose sex life is caricatured as the exploits of the man of few words: He meets women; he "asks them all." As a description of man, the picture of this rutting he-goat is a trifle oversimplified. So, one may think, is the picture of the work-happy Simple Simon of the New Class. It is an inadequate sketch—even if limited to a single class.

To characterize by a single attribute, is a habit of many students of humanity. This is the practice of synecdoche, which makes for good rhetoric, bad manners and poor science. A "sail" is a picturesque description of a ship; but there was more to a frigate than the canvas she spread, as the *Constitution* demonstrated when she met the *Guerrière*. A "drunk" is a vivid term, but it describes a symptom, not a personality; no alcoholic is flattered by it; and it is no help in therapy (bad manners seldom are a help in therapy).

Psychiatry, in which diagnostic labels are used to classify the unlike as the like, is no freer of guilt than the other disciplines dealing with mankind; but for really felonious behavior as compared to psychiatric misdemeanor, consider the economists. If psychiatry deserves mild lampooning for the picture of rutting libido-man that simplifiers sometimes draw, what is to be said for the culture-wrecking concept of economic man?

Professor Galbraith's subspecies of human is an improved strain of the standard economic breed—a hybrid, out of Pollyanna by Economic Determinism, presenting a pretty problem for the scientific handcapper. Like libido man, or better, libidinous man, the new specimen is a one-purpose creature, all-weather, all-track performer. To compare them is to take parts for the whole and unlike parts at that, assume that one has the whole, and attempt to account for complete performance. To expect scientific progress with such concepts, is to expect a real race when the sole qualifications for entry are that the racer must either be piebald or a gelding.

But suppose that, without more than ordinary prejudice, one were to study Professor Galbraith's entry. His New Class man is a variety who is depicted as peculiar to, and perhaps only possible in, a society where nobody is in danger of starving. The cornerstone of the structure of man as raised by the economists (orthodox as well as Marxian) is based on hunger. The primary

aim of economic man is to fill his belly—as often and as thoroughly as possible. To make the picture fit libidinous man, simply substitute "women" for "belly." But suppose one considers man without the benefit of either limitation, from what the scientist (who may flatter himself) would consider a scientific viewpoint, meaning an as objective an all-around view as possible.

Man is a living organism, sharing certain characteristics with other organisms and having a few that appear to be unique possessions of the human species. Among those he shares are what have been commonly called the primal instincts of hunger and sex, instincts that were usually dressed up in Victorian days in the respectable clothing of self-preservation and preservation of the species. Self-preservation, or the finding of good capon for the lining of man's fair round belly, is the basic activity of economic man, as race preservation, or *cherchez la femme* is supposed to be the life theme of libidinous man.

These pictures have the attraction of simplicity. If a thing is too complicated for ready understanding, the temptation is always to simplify it. The simplifier undertakes to understand human behavior by translating self-preservation into conditioned reaction —Pavloff's bells ring, and the man-dog, homo familiaris Canidae, salivates. Or the simplifier translates the human "instinct for preservation of the species" into a picture of the sex life of Yerkes Laboratory apes. In these rough sketches, man is an automaton, a living machine. One presses the hunger-button or the sex-button, observes the reaction, and understands all about him. There is no need to suppose here that either the economist or the psychiatrist really thinks it is all that simple; but these are the impressions that are often given.

When they are fitted into the whole structure, the satisfaction of hunger and the satisfaction of sex are parts of a vast complexity. The psychiatrist who follows Freud ordinarily thinks of both as functions of a single force, libido—the energy of the life instinct, or the energy invested in the human organism's instinctual drives for pleasure, or for living and mating. The way man reacts, economically or in sexual morals and mores, is a derivation from this basic energy; a reaction can neither be seen in perspective nor understood if it is mistaken for the primal energy itself, or is considered without relating it to its primary source. Furthermore, a human reaction cannot be understood without

realization that it is influenced by more than a single energy-stream. Whether Thanatos is, like Eros, a primary instinct, as Freud believed, or whether it is an early deflection and distortion of force derived from the life instinct, is immaterial to the observation that man's gains in life are accomplished over inner opposition, over an inner urge to destroy, to undo. His economic status and economic aims, no less than his love life, are the outcome of his inner struggle—complicated by numerous other circumstances of environment and/or psychosexual conditioning.

But even this somewhat elaborated sketch is still incomplete and in bad focus. Its picture of man is largely of man without his conscious. Man's actions may result from conflicting instinctual and outer forces; but they are shaped and directed, or so we sometimes think, by conscious intellectual and emotional influences. Just how powerful the conscious may be is beside the point; one must at least recognize its existence. Here, too, is the problem of recognizing will or volition—whatever it is; to understand man, one must take into account a powerful intrapsychic force that is not well understood itself and that science cannot satisfactorily explain.

Here we have the question of determinism versus free will. We trace the recurring operation of cause to effect, and new cause to new effect, all through natural science from quantum mechanics to astrophysics (making due exception in quantum theory for the operation of the uncertainty principle). We trace cause and effect through life phenomena, chromosomes, genes, cell structure, and behavior from tropisms to Pavloff's conditioned reactions. The philosophy of cause and effect is the philosophy of determinism; it is the essential philosophy of science and, on the whole, an eminently satisfactory one. It is eminently satisfactory because it explains.

But somewhere in the biological process, or maybe the evolutionary process, determinism ceases to explain. That is: It either ceases to explain satisfactorily, or we cannot see the explanation. It becomes necessary for practical purposes to assume processes and reactions that are not entirely predetermined. We can conceive readily that an amoeba is an organic mechanism, a living machine—in its career of ingestion, elimination, phototropism, division and conjugation. So, we may think, is an angleworm, or an oyster, or a jellyfish. But further, if not necessarily higher,

along the evolutionary scale, living things behave as if a new factor were at work. These "higher" living creatures appear (whatever the fact may be) to be able to decide things. Simple as his preceding mental processes are, a frog appears able to choose whether to jump or sit still. And dog, cat and Yerkes Laboratory ape all appear to exercise what human observers must describe as choice and volition, even if the observer has mental reservations to the effect that all, all are reflexes and that there are no such things as choice or volition. So it is with human actions.

An element of what we usually call choice enters into the behavior of the most economically-determined (or libidinously-determined) man. Man appears to have at least limited choice of both sex objects and economic objectives. Of course both genetic and environmental factors enter into whether he prefers Hottentot or Polynesian or Caucasoid women; but, assuming that he prefers the Caucasoid, who is going to account completely by such factors for his choice of short or tall, fat or thin, lively or placid, bright or stupid, blonde or brunette? Or, consider the man for whom a professional career seems genetically, economically and environmentally determined. Psychiatry can uncover some of the unconscious reasons behind choice of the man's actual profession; but even analysis cannot be certain that all the reasoning which masks the unconscious is rationalization. Admitting much instinctual and emotional reaction in both situations, there still appears to most observers to be a residue of mentation contributing to the phenomenon called choice.

There has been much psychoanalytic theory and considerable clinical verification of factors determining choice of occupation. Environmental influences, including economic circumstances, are certainly among them. The psychiatrist may advance the broad contention, for example, that an anal-erotic character configuration may tend to direct its possessor toward bricklaying, banking or industrial leadership; that the addition of exhibitionism to anality may produce sculptors or painters; that oral exhibitionists become actors and lawyers; that sublimated voyeurs become detectives, astronomers, journalists, Kinsey-questionnaire composers, Congressional investigators, hoboes and psychiatrists. The psychoanalytic theorist would be the last to disclaim that economics enters into this. Economics, as well as intellectual endow-

ment, may determine whether the voyeur becomes a hobo or an astronomer, or whether the anal erotic character becomes a bricklayer or a banker.

This discussion is an attempt to add substance—a third dimension—to our ordinarily half-sketched concepts of man. The economic man and the libidinous man are only two among an infinity of possible caricatures. There is, for instance, masochistic man, who is probably closer to an accurate picture than either of the others, for powerful evidence has been adduced that masochism, whether fixed in the oral stage of development or in the death instinct, is close to the basis of most "normal" people's mental abnormalities, besides the abnormalities of people not so "normal." But that also is an incomplete picture of man; if man were wholly and helplessly masochistic (and were here at all), he would not recognize masochism as abnormal. The rest of the picture involves other forces.

There are other persuasive arguments of why man is what he is. A distinguished anthropologist presents a picture of "culture man."* If the argument is followed correctly here, it is that man is not only the creator of culture but is the creature of culture. The cultural machine, first set in motion by the tools and the tongues of the cave men, has grown into a Golem to dominate the race that made it. Culture is a force subject to no laws but its own, and man is helpless in its hands.

There is, too, the persuasive concept that man is what he is educated to be. There is strong belief, and most scientific men hold to it, that education is the best hope for the future of man and society. Some would further specify that liberal education** is the kind we need. Thrown not too far out of focus, this is a picture, not of educated man, but of education-man. Education-man, it may be presumed, cannot only control his individual destiny within limits, but can control the culture that culture-man is helpless to control.

The psychiatrist would hold that the trouble with education-man is that his ability is unequal to his aspirations. His conscious efforts are surrounded and deflected by unconscious moti-

*White, Leslie A.: The Evolution of Culture. McGraw-Hill. New York. 1959.

**Griswold, A. Whitney: Liberal Education and the Democratic Ideal. Yale University Press. New Haven. 1959.

vations, and he must cope with the environmental forces that economic-man believes are fundamental.

The aim of psychiatry since Adolf Meyer's time has been to "see man as a whole." No view presented here, including psychiatry's, does see man as a whole. Most of us see a little more than a picture of farming-man, shirt-selling man, coin-collecting man or psalm-singing man. But none of us has a view that truly comprehends man in toto. Grinker* comes closer: He says that we must view the total man in his entire organismic-environmental transactional field—not as a static snapshot but as a panorama of a dynamic ongoing process at conscious and unconscious levels.

Consider, again, Professor Galbraith's man of the New Class. He is man with a conscious economic motivation, though not primarily the motivation of gathering wealth. Instead, his concern is with his comparative social status, with social approval and with self-satisfaction (or with the stuff of his compulsion). But economic man has always sought social recognition (sometimes as approval and sometimes as fear) with self-satisfaction (whether with wine, women and wagering, or with intellectual pursuits). The man of the New Class is economic man, seeking status by means of more or less intellectual, and presumably pleasurable, activities.

This is neither to deny the existence nor to decry the importance of the New Class. It is visibly here and visibly important. The only new thing about it is the word new. It was here three hundred years ago. When the New England colonies were founded, it made up the "intellectual aristocracy," or perhaps "educated leadership" would be better, of the new settlements. The New England colonies never imported the squirearchy, as did Virginia and the deep South; their few settlers from among the hereditary aristocracy were soon absorbed in the general population; their "upper classes" were largely made up of the dominie, the doctor, the lawyer and the schoolteacher—with perhaps a surveyor and a college-bred merchant or farmer. There were merchants and wealthy merchants, of course, farmers and wealthy farmers, sea captains and wealthy sea captains; but wealth was never completely stratified; society was largely organized, as in the small towns of New England today. It must have resembled a New England apple pie—with a sound and generous filling of farmers and tradesmen, sweetened by a few inn-keepers and an artisan or

*Grinker, Roy R.: Psychosomatic Research. Norton. New York. 1953.

two, and with a thin upper crust of the educated—meaning the relatively educated.

With apologies to the historians and a reasonable readiness for correction, it can be submitted that the "educated" leadership of the New England colonies—a leadership that went west with our pioneer settlements—was the New Class that Professor Galbraith is discovering today. It was not confined to New England; it spread through the middle colonies; and it spread through the South and through New York, where its growth does not seem to have been hampered by the presence of land-owning aristocracies of the traditional kind. The New Class is an expression of a reaction type specific to human behavior; it is not new; it is not a class. The theorist can trace it to a combination of at least average intellect with a little more than average instinctual energy, directed by genes or circumstances into sublimated forms of voyeurism and exhibitionism, learning and the parade of learning.

The phenomenon is not a simple response to the economic forces of capitalistic society. It existed long before modern capitalism; the New Class of the Middle Ages was found largely in the church, where education was encouraged and the educated were uninhibited by the strict bounds which limit clerical behavior today. The New Class existed in Imperial Rome, where slaves or freedmen might and did attain eminence in literature, medicine and science generally. It may be stretching analogies much too far, but one is tempted to wonder if the New Class did not begin to emerge from the mass when civilization first rose from neolithic barbarism. If so, could that first example of "universal genius," Imhotep, architect, physician and civil administrator, be considered the founder of it?

A difference between Imhotep's Egypt and today may be that membership in the New Class seems far more desirable to people in general today. There is here, indeed, among other things, a strong economic (or political—or psychological) influence. In days when power was concentrated in the hands of military leaders, or in those of families which had the ability to seize and hold land, or to acquire and keep money, many men who may seek leadership today through membership in the New Class, might have turned their efforts instead to soldiering, or to attaining place among the landed or moneyed aristocracy. The attractions of such a course

are probably less today than for many centuries. Only a handful of soldiers in the whole world can reach eminence today—and that more by accident than by military aptitude—while in times past the warrior Acheans or the marauding Normans or the Italian condottieri could carve out baronies and duchies and principalities by the score. There is no landed aristocracy in America to which a man might aspire for power today; and in the countries where such still exist, their power is rapidly disappearing. As for America's very rich, their position recalls the frontier days when physical strength meant dominance—while Colonel Colt made equalizers. Money-power, like physical strength, has had its era of dominance in America; one has only to recall Theodore Roosevelt leading his progressive Republicans in a wild charge against "malefactors of great wealth," and Franklin D. Roosevelt summoning his new deal Democrats to beseige the fortress of "economic royalty." But since—two World Wars and other circumstance have brought in equalizers; taxes which promise to rise to the point where either great income or great inheritance will hardly be worth the bother of collecting. The member of the New Class is less likely than ever before to be lured away to try to make a fortune.

This much, one may readily concede to Professor Galbraith's economic forces: It is easier to attain the New Class today in an economy of plenty; and competition, the lure of other groups for ambitious members of the New Class, is less keen than previously. But the real, not the ostensible, motivation of the New Class is only in part economic; it is a mixture of the genetic, psychological and environmental forces which have always impelled certain types into the occupations the New Class represents—and for the same reasons that impel today's New Class, enjoyment of work (and so, better work), rather than derivation of wealth from it. (But will it produce more compulsive children whose attitude toward work will be even more pathological than in the past?) Today's New Class is, of course, welcome—and for other reasons than the economic. If its growth makes our people economically stronger, as seems probable, it also makes them intellectually stronger, and —one can argue—politically freer and more stable. It has such beneficial results principally because it isn't a class at all; it is not self-perpetuating; and it is not truly exclusive. Its members may associate by choice primarily with each other; but they do

not exclude qualified new members, and it is difficult to see how they could. Its lines cut across existing social, ethnic, religious, and political groupings. It is as catholic in its welcome to the egg-head as was the medieval church; and its welcome is wider than to the egg-head alone, for the condition of admission (as Galbraith sees it) is that the New Class member work for the pleasure in working, not for profit. He may star-gaze, feel pulses or write verse, and thus qualify as an egg-head; but he may also sell things for the joy of selling or make things with his hands for the joy of making. Either way, he is an honest and recognized member of the New Class. All these trends are in the direction of progress; they represent democracy, improved leadership for democracy, and perhaps improved mental and social hygiene. Also, they represent another very desirable thing socially—fluidity. For the New Class, be it remembered, is not a class.

Professional families cannot be sure to perpetuate themselves, though most try to do so, and some of them succeed. The New Class cannot perpetuate itself for the same reasons that the professional family cannot. A child may be kept in a landed aristocracy by laws of inheritance. He may be kept (though probably not many generations of his descendants) in a moneyed class, by such instruments as trust funds. But there is no power of nature or man to keep a child in the New Class unless he wants to belong to it. And this reduces the New Class—despite valiant individual struggles cited by Galbraith—from a stratum to a sort of shifting social agglomeration. Or perhaps what it does is raise it from a stratum to a shifting social agglomeration. At least the traditional laws of class formation, or of economics, do not appear to apply.

Man of the New Class is not economic-man. Economic forces shape only a part of man's external environment, which, in turn, forms only part of the forces influencing man's course in life. In relation to the New Class, economic forces are powerful, but it may be questioned if they are anywhere nearly powerful enough to be determining. Some consideration has been given in this discussion to other operative forces: primary instincts, personality configuration, specific complexes, volition (whatever it may be), and education. And a whole library of textbooks could be written on the influences that the ego ideal and the super-ego, the so-called unconscious conscience exert on social and personal development.

To point this out, is to cast no aspersions. Professor Galbraith is an economist; and economics, like psychiatry, is a full-time occupation. When a psychiatrist deals with man, he is likely to overemphasize emotion and mentation, and to underestimate even some psychological factors, such as volition, the strength of the conscious part of the mind, and the influence on thinking and feeling of formal education. The psychiatrist is unfortunately particularly apt to take too little account of economic factors. With the growth of social work services and the improvement in psychiatric social work technique, psychiatry is correcting this situation; and well-oriented psychiatrists now try to see that the patient's mind is at rest about his economic problem—either as part of psychiatric treatment or preliminary to it. But psychiatry plus economics give only two of numerous possible views.

Professor Galbraith's economic man of the New Class can do service to psychiatry by way of warning against setting up psychiatric man as a class. An interdisciplinary realization that man cannot be classified by disciplines would do much better service. The anthropologist needs to keep in mind that man is neither a collection of skeletal measurements, nor a bundle of strange customs; the anatomist, that he is not simply an animated cadaver; the sociologist, that he is more than a unit in a crowd; the theologian, that he is more than a soul to be saved; the economist, that he is not a monetary unit; and the psychiatrist, that he is more than a generally deplorable bundle of complexes.

It is submitted that the student—whether of economics or of psychiatry—should start by learning that he is only surveying a limited area of a wide terrain; that he can see, at most, part of one small side of a huge phenomenon; that to understand the little he can see close at hand, he must try to have a general idea, at least a misty comprehension, of the far-stretching whole. The man who surveys the nineteenth century will have a myopic view if he focuses his attention on the industrial revolution, the American Civil War or the poetry of Alfred Lord Tennyson; he must see them all, and a thousand things more, if he really wants to appreciate what our ancestors did, how our ancestors thought, and how our ancestors lived. The man whose study touches, not a mere century of human development, but the elements, the fabrication and the functioning which constitute mankind, can have no really enveloping grasp; the object is far too vast. But he and

his specialty should be oriented; and the textbooks, from Galbraith to Freud, should endeavor to supply at least an orientation outline. It is the contention here that none of them do—and that neither school, nor university, nor the ordinary experience of life itself, does much in the way of sketching in this essential background of orientation for specialists in the numerous separate sciences of man. The situation calls for a great interdisciplinary effort, which may be of even greater importance than magnitude.

Man is about to rocket from the surface of his familiar planet to unexplored space; the engineering has been worked out; the plans have been made. The man who catapults forth will not be economic man, military man, literary man, golfing man or psychiatric man. He will simply be Man. Both humanity in general and the scientific specialists—from economist to psychiatrist—need to learn more about him.

BOOK REVIEWS

Parental Authority. By JULIUS COHEN, REGINALD A. H. ROBSON and ALAN BATES. 301 pages. Cloth. Rutgers University Press. New Brunswick, N. J. 1958. Price $6.00.

Parental Authority is a collective research from points of view of law and sociology. It concerns a comparison of community attitudes toward the proper extent and proper exercise of parental authority and the actual law on the subject. The procedure was modeled on the Kinsey questionnaire method. The aim was to determine the "moral sense" of the community in the area specified and see how that moral sense compared with the law. The authors believe that the results of their efforts will be of use in both law and social science.

The book is subject to the general criticism which can be made of all questionnaire surveys. Let it be assumed first that the sample questioned is sufficiently representative and the method of questioning unexceptionable. The fact remains that the moral sense thus revealed is the conscious moral sense that the subjects choose to profess, not the moral sense that the student of dynamics would seek to find in the underlying character structure. What the subjects of this study actually felt and believed is, therefore, less than perfectly reflected in their questionnaire answers. What they professed, however, is of both interest and use to the student of the human mind and of human relations. The work should be valuable to social scientists, psychologists and psychiatrists who keep its limitations in mind.

The Quality of Murder. By JOHN HOLLAND CASSITY, M.D. 268 pages. Cloth. Julian Press. New York. 1958. Price $4.50.

Dr. Cassity discusses problems of forensic psychiatry from the viewpoint of modern psychiatric thought and the outdated law we have inherited. He writes of such famous cases as that of the undoubted schizophrenic, Guiteau, who was executed for the assassination of President Garfield; Harry Thaw who, the author believes, should have been imprisoned for life; Richard Loeb and Nathan Leopold and others. His book is a simplified but very clear presentation of the case for disposing of mentally ill criminals on the basis of their mental illnesses. If Thaw were to be tried today, he thinks, he would have been institutionalized for life. And he remarks: "According to our present interpretation of law and psychiatry, both Loeb and Leopold should have suffered the full penalty for their crime and Leopold, even 33 years later, should not have been released." But he adds that if Leopold does justify the faith shown in him, "it will indeed be a fortunate achievement."

This is the best book the reviewer has seen for the popular presentation of the modern psychiatric viewpoint in serious criminal cases. It is adapted for general as well as for professional reading.

Insanity, Art, and Culture. By FRANCIS REITMAN. 111 pages. Cloth. Philosophical Library. New York. 1955. Price $3.75.

In this provocative exploratory study the author has set himself the task of determining if one may properly speak of "psychotic art," or more specifically, if the artistic productions of the psychotic patient are symptomatic of diagnostic category. A second problem is the generality of the typical characteristics of "psychotic art" across cultural boundaries. Differences between the artistic productions of psychotic patients from different cultures would presumably reflect cultural determination, and not features unique to psychosis. Dr. Reitman obtained samples of the artistic work of patients from "western society," India, Egypt, Mexico, Africa, Ceylon, and the Maori of New Zealand. Unfortunately, only the Indian and Ceylonese groups, of the non-western societies, provide anywhere near an adequate sampling.

An analysis reveals that the following features were characteristic of "psychotic art" of the western society (Great Britain and the Continent of Europe primarily): fragmentation, emphasis upon geometric patterns and symbols, the writing of neologisms into the design, over-elaboration, i.e. filling in all the space, bizarre use of color, and ornamentalism. All of the examples of "psychotic art" from non-western societies contained at least a few of these characteristics. But a sign must be interpreted in light of its cultural norm. Ornamentalism, while pathologic in western art, may well be culturally-conditioned in Japanese art.

A similar analysis is made of other art forms. It was found that sculpture occurred too infrequently to evaluate. Needlework, however, displayed symptomatology quite comparable to psychotic paintings. In all, Dr. Reitman has presented an interesting and stimulating discussion.

One Man in His Time. By N. M. BORODIN. 344 pages. Cloth. Macmillan. New York. 1955. Price $4.50.

This is the life history of a Russian scientist who, while on a mission for the Soviets in London, refused to return home. The author freely admits that his act was "a move of instinctive self-preservation." He does not even pretend that enthusiasm for democracy prompted his decision. The book gives highly interesting details about the misery, starvation and fear, to which the Soviet "paradise" subjects its victims. Especially interesting are the chapters dealing with the secret terror-police and the situation after the Nazi attack in June 1941.

The Polish Peasant in Europe and America. Two volumes. By WILLIAM I. THOMAS and FLORIAN ZNANIECKI. 2250 pages including index. Cloth. Dover. New York. 1958. Price $12.50 per set.

The Polish Peasant in Europe and America is a classic sociological study. The authors surveyed individuals, families and communities in Poland, Germany and the United States during the early years of the century. The social and political situation when the study was first published was radically different from that of today—in America as well as in Europe. The countryman in Poland under the Czars was a member of a closely-knit familial organization which sometimes survived emigration. The authors comment on the situation in the United States of that day. The Polish immigrant had retained his habit of familial solidarity and was re-creating in this country the community solidity to which he was accustomed in Poland.

The authors comment at one point that "the formation of a new Polish-American society out of those fragments separated from Polish society and embedded in American society" was the usual process of acculturation, rather than the assimilation of individuals. Strong elements of this trend, of course, survive today, although the process of individual acculturation has almost taken its place.

The two volumes of the present work are reprints of the second edition. The study was originally in five volumes; and the present two-volume edition is unabridged and otherwise complete. If this work does not touch on dynamic psychology, it should also be noted that it is not statistical; in method and conclusions, it could justly be called clinical. It contains, besides conventional surveys of various aspects of cultural, social and religious organization, numerous letters between immigrants and their families and the long life story of one individual, written especially for the survey. The work should be of interest to any social scientist and could well find a place in any library of social science as a model for future projects, including surveys in the psychiatric field.

Le Test de Rorschach et la Personalite Epileptique. By J. DELAY, P. PICHOT, T. LEMPÉRIÈRE, and J. PERSE. 218 pages. Paper. Presses Universitaires de France. Paris. 1955. Price 1,000 francs.

Le Test de Rorschach et la Personalité Épileptique by J. Delay, P. Pichot, T. Lempérière, and J. Perse, is a commendable presentation in scientific and objective outline of the field of epilepsy studied through the Rorschach test. The authors of this volume consider the Rorschach to be one of the most important contributions by the psychological services to the study of epilepsy. In their evaluation they trace the history of the epileptic personality in terms of symptomatic, constitutional, psycholog-

ical, temporal, and psychoanalytic viewpoints. The bibliography is extensive and comprehensive.

The book presents the epileptic personality in terms of modern theories, the history of the Rorschach examination of epileptics, and case histories showing the use of the Rorschach in epileptics. The clinical observations are sound; the conclusions are valid; and the authors have made a basic contribution to the study of the Rorschach in terms of the personality of the neurological patient generally.

The book *Le Test de Rorschach et la Personalité Épileptique* is written in French; but those therapists and clinicians sufficiently versed in French can benefit greatly from a study of this volume. The book contains protocols, clinical observations and case histories; and the conclusions reached by the authors supplement this strong volume in the field of clinical psychology.

Art Therapy in a Children's Community. By EDITH KRAMER. XVII and 238 pages. Cloth. Thomas. Springfield, Ill. 1958. Price $6.75.

The author describes the basic aim of the art therapist as "to make available to disturbed persons the pleasures and satisfaction which creative work can give, and by his insight and therapeutic skill to make such experiences meaningful and valuable to the total personality."

Art therapy's role in the total care of the emotionally disturbed is yet to be fully evaluated. This reviewer believes this book to be very useful toward this end, though by no means the "last word." The approach is from the point of view of the person actually doing the therapy, and the problems presented illustrate the practical aspects. The theoretical basis is not ignored or slighted, but there is emphasis on many useful guides to the handling of situations that might aid in the working out of a program.

Surgeons All. By HARVEY GRAHAM. 443 pages. Cloth. Philosophical Library. New York. 1957. Price $10.00.

Not only is *Surgeons All* an extremely compact book, it is also immensely interesting and well written. Dr. Graham treats his subject chronologically. He starts with prehistoric trepanning and works through classical surgery, the Black Death, barbery, John Hunter, anesthesia, and Lister, and ends with a discussion of lung cancer.

But it is really the sidelights that make the book. When a book is filled with the idiosyncrasies of famous persons, and explains besides why they are famous, while still presenting the subject in an intelligent manner, we have a history that is well worth reading. Such is *Surgeons All.*

Surgeons All was published in the spring of 1939, but—as the present publishers believe it did not get a fair chance—has been published again with the inclusion of a "Postscript 1939-1956."

Theories of Perception and the Concept of Structure. By FLOYD H. ALLPORT. 708 pages. Cloth. Wiley. New York. 1955. Price $8.00.

This work is a conscientious, scholarly summary and evaluation of theories of perception, a work much needed in psychology today. For recent years have witnessed a vigorous and at times uncritical revival of interest in the problem, which actually was the historic source of much of psychology's original concepts, methodology, and problems. The range covered by the author is considerable, encompassing the bulk of psychological theorizing from the late nineteenth century to the present day.

Beginning with a discussion of the classical theories, their methodological formulations, and their self-conscious concern about the mind-body problem, the author traces the rise of the nativism-empiricism controversy, the interest in configurations in perception, and the origins of Gestalt theory, and its major concepts and discoveries. One of the more important derivatives of Gestalt theory, the topological field formulation of Lewin, is considered in some detail. The more recent theories are amply discussed. Among these are: Hebb's concept of the cell assembly and the phase sequence as the basis for perception; the Werner-Wapner sensory-tonic hypothesis; Helson's adaptation level concept; Brunswilk's probabilistic approach; the "new look" perception emphasis upon motivational determinants; and the "transactional" approach of the Ames group.

Mine Enemy Grows Older. By ALEXANDER KING. 374 pages. Cloth. Simon and Schuster. New York. 1958. Price $4.50.

This is the autobiography of a bizarre man who tried his hand at a variety of jobs, such as painter, book illustrator, idea man at *Life*, editor of a theatrical magazine, and playwright. At bottom, despite all his pseudo-sophistication, the author gives the impression of a child desperately trying to shock; he is proud of his innumerable prejudices: "This book... carries the rich distillation of my carefully considered hates and prejudices... I'm not at all interested in giving the false impression that I'm trying to be fair to anybody." If the reader is willing to tolerate silly prejudices for the sake of faintly amusing stories and to wade through bias against women, psychiatrists, human nature and *Time* magazine, he is welcome. How little the author understands his own self-damaging lifeline, is visible from a record of 10 years of addiction, including three visits in Lexington, Ky.

Pray Your Weight Away. By the Reverend Charlie W. Shedd, D.D. 158 pages. Cloth. Lippincott. Philadelphia. 1957. Price $2.95.

This is the story of a minister who solved his personal problem of overweight through his religion. He stopped eating fattening foods, limited his food intake, and reinforced his determination through prayer. His method may be of practical use for those with similar convictions.

Shelley: The Last Phase. By Ivan Roe. 256 pages. Cloth. Roy Publishers. New York. 1955. Price $3.75.

Shelley presents an irresistible challenge to the biographer. The misery, rejection, and failure through which he wound his way, not only make up a story of the intense, and at times mysterious, motivations of an unusually gifted and sensitive man, the author tells us, but also are an unhappy commentary upon a hypocritical and maliciously cruel stratum of the society of his day. The present work throws new light upon the circumstances surrounding the tragic end of the poet's life. The author's account enters upon the last 69 days, and, in exacting detail portrays the day-to-day events, the bitter and complicated emotional interplay, and the lonely and frequently oppressive atmosphere within the Shelley household those last days.

Best Cartoons of the Year 1958. Lawrence Lariar, editor. Unpaged. Cloth. Crown. New York. 1958. Price $2.95.

This is another fine collection of illustrated human foibles. Psychiatry comes in for the usual amount of attention, and a good deal of the other material can be best interpreted along Freudian lines. The dog with claustrophobia and the shipwrecked gentleman begging for a coconut are particularly good examples. The psychiatrist will also appreciate the cartoon of the analyst as a headshrinker. The production is printed beautifully, as usual.

What is Creative Thinking. By Catherine Patrick. 210 pages. Cloth. Philosophical Library. New York. 1955. Price $3.00.

One of the most difficult of problems that confront the psychologist is the explanation of what is commonly called "creative thinking." It is also one of the most exciting of problems. Unfortunately, it is a form of behavior that is as yet not easily susceptible to experimental study. Consequently, the most frequent source of data has been the introspections of the creative mind at work. The present work draws primarily upon such material. In her analysis the author makes the traditional distinction within the creative process between four different steps: preparation, incubation, illumination, and verification or revision. The author has said nothing new, and has not thrown any new light upon the subject. However, she has provided a relatively complete summary of conventional views that should prove of interest to the lay reader.

Brotherhood of Evil: The Mafia. By FREDERIC SONDERN, JR. 243 pages including appendix. Cloth. Farrar, Straus and Cudahy. New York. 1959. Price $3.95.

The brotherhood of evil is the Mafia. The Mafia is a sociological and psychological phenomenon of vast importance in Italy, in the United States and in international crime. The Mafia is a "secret" society, and Sondern's account of it here has been challenged as to general facts and in detail. This reviewer, like most, lacks the specialized knowledge to judge its accuracy. Mr. Sondern's picture, however, comes largely from governmental records, with much off-the-record information added from government agencies which have been combating the specific varieties of crime in which the Mafia engages. The record also makes sense psychopathologically; and the reviewer is inclined both to accept it and to recommend its study.

Sondern hangs his narrative on the famous meeting at Applachin, N. Y. in 1957, which was raided in what the author reports as the greatest calamity ever to befall the Mafia. The Mafia, it appears, is a tight but informal organization of Sicilians who derive their tradition from opposition, far in the past, to governmental tyranny. It has developed into an organization contemptuous of all government, good or bad, and devoted to breaking any law or principle of morality of which the breaking promises profit. The Mafia's latest activities have been in the narcotics field. Drastic efforts at prosecution now appear to be effective in greatly curtailing the narcotics trade, or at least in driving the Mafia out of it; and it has more than once been suggested that the Applachin meeting was called to make plans for getting the Mafia out of an increasingly dangerous operation.

Sondern's book takes up a number of points of particular interest to psychiatry. The Mafia has a moral code of its own which is worth studying. The operation of a social group dedicated to law-breaking is another point of interest. Finally, the problem of drug traffic involves measures for prevention, suppression and treatment of addicts, all of which are of psychiatric concern.

Doctors' Legacy. By LAURENCE FARMER. 257 pages. Cloth. Harper. New York. 1955. Price $3.50.

Here is an interesting collection of letters written by physicians during the last 200 years. Though progress in thinking is slow, the progress of medicine has been relatively rapid. All this can be traced in these letters, from despair over quackery, and attacks on every innovation to the humanitarianism of medical men confronted with ignorance and prejudice. In any case, the times in which Rabelais, himself a physician, said that the practice of medicine is "but a farce played by three actors: the physician, the patient and the disease," are over.

The Pistol. By JAMES JONES. 158 pages. Cloth. Scribner's. New York. 1958. Price $3.00.

This much-discussed short novel is, without being labeled as such, a piece of readily-recognized symbolism. It is also, as the author's name should warrant, a splendid evocation of the World War II G.I., his ways of thinking, and his behavior. Any social scientist and anybody else who is at all interested in dynamic psychology should find it well worth reading—and entertaining besides.

The Science of Culture. By LESLIE A. WHITE, Ph.D. 444 pages including name and subject index. Paper. Grove. New York. 1958. Price $1.95.

This book is a paperback reprint of a volume by an eminent anthropologist. It was issued originally in 1949, and is a compilation of articles giving the anthropologist's point of view on various subjects of psychological interest, ranging from semantics to incest. Professor White aims this collection toward a plea for the development of culturology as a science. He believes that human behavior is "a function of culture." Culture, he thinks, should be studied like any other "extra-somatic" phenomenon. He feels that man's assumption that he can control civilization through social science is a fallacy. Instead of man controlling culture, culture controls man—wars and all. The student of dynamic psychology may quarrel with this; but the viewpoint is an important one indeed; and this book is an excellent student's introduction to it.

Cast The First Stone. By J. M. MURTAGH and SARA HARRIS. 302 pages. Cloth. McGraw-Hill. New York. 1957. Price $4.50.

The senior author is chief magistrate of the City of New York. The book aims to give a description of prostitution, outline the legal procedure involved, and discuss the genesis of the practice. The first two objectives are well met. Strong criticism against present handling of the problem (jail) is voiced. The third aim—to explain the genesis of prostitution—is missed. What seems to be enmity toward psychiatry can be read between the lines: "How do pimps manage to keep their stables? Nobody knows the answers: not judges, or police officials, or psychiatrists, or social workers. The mistake they make is to think they know." Other opinions expressed about prostitutes and their customers seem psychiatrically naïve. Although the author repeatedly stresses the fact that prostitutes "are people narcotized to accept hurts, humiliations, abasement as their daily portions," it does not occur to him to inquire from psychiatrists what this well-known tendency denotes.

The Will to Doubt. By BERTRAND RUSSELL. 126 pages. Cloth. Philosophical Library. New York. 1958. Price $2.75.

This is a pocket-sized book of a dozen of Russell's penetrating essays, dealing with intellectual freedom in today's society, and with the philosophical and scientific grounds for belief in the possibility of rational behavior. For example, "Can Man Be Rational?" is a brilliant discussion of the general scientific principles underlying the possibilities of human rationality. Man can be rational at times, Russell thinks, and his times of rationality can be increased. Of psychoanalytic treatment and its purposes, he remarks, "This is the exact opposite of that lazy acquiescence in irrationality which is sometimes urged by those who only know that psycho-analysis has shown the prevalence of irrational beliefs, and who forget or ignore that its purpose is to diminish this prevalence by a definite method of medical treatment." One hardly needs to remark on the value of such a contribution to the understanding of psychoanalysis and psychiatry and to the cause of mental hygiene in general.

The reviewer thinks, however, that the general worth of this book is greatly reduced or destroyed by the failure of the editor or publishers to date the essays contained in it. There is nothing but an acknowledgment—under the copyright notice—of an arrangement with Russell's British publishers to show that the essays presented here are not new but are selected reprints. This necessitates a most irritating amount of concentration on the part of the reader to make sense of them. For instance, Russell writes of Communist Russia as a society where free love is encouraged, a policy that was changed around 30 years ago; and he refers to current conditions in China which preceded the Communist dictatorship and probably preceded the Japanese invasion. Internal evidence—which can be recognized if one's memory extends 40 years back, or if one has a most exceptional knowledge of very recent history—indicates that six of the book's 12 essays were written between World War I and World War II, at least two of these in the 1920's. Of the rest, one may have been written during World War I, one possibly before World War II and revised afterward, and a third any time between World I and 1950. The other three contain no material to make the author look ignorant of current events—regardless of when published. The reviewer sees no advantage to anybody in a series of omissions calculated to make younger readers of the book wonder what on earth the author is talking about; and he considers the performance inexcusable.

The Heart is the Teacher. By LEONARD COVELLO with GUIDO D'AGOSTINO. 275 pages. Cloth. McGraw-Hill. New York. 1958. Price $4.75.

Leonard Covello was brought to this country as a child, a poverty-stricken immigrant from Italy. This is his autobiography as set down in

his old age. It covers the sweeping changes which have taken place in the social organization of New York City since the author's childhood, recounts the changes in the schools, and surveys the modern educational program.

Dr. Covello was for 22 years principal of a high school in a problem district of New York City. His book is a fine contribution to social hygiene and mental hygiene.

Economics of Mental Illness. By RASHI FEIN. XX and 164 pages. Cloth. Basic Books. New York. 1958. Price $3.00.

This is the second of a series of monographs to be published by the Joint Commission on Mental Illness and Health. The author approaches the problem from the total expense aspect measuring both direct and indirect costs. In other words, one must not only estimate the cost to the state of one year's hospitalization, but also the loss of earnings during this period of the person hospitalized. The author has modified his raw statistics to cover many factors that affect this general situation. He is commendably cautious about the drawing of conclusions. This book is a basic reference that belongs on all psychiatric library shelves.

Of Stars and Men. By HARLOW SHAPLEY. 157 pages. Cloth. Beacon Press. Boston. 1958. Price $3.50.

A distinguished astronomer examines in this book the relations between man, his planet and his cosmos. Shapley thinks that there probably has been or is—in our own solar system—life on Mars as well as on the earth. He "personally" estimates that there are "at least 10^{14} high-life planets" in the cosmos. He discusses the conditions for life on earth and the possible hazards of life on other life-bearing planets.

In our day a great deal of potentially free-floating anxiety has been attached to the future of the human race. Aside from the possibility that the human race will eliminate itself, Shapley is an optimist. He thinks the chances are good that man will be on earth a thousand years from now "but not surely for one hundred thousand." He thinks: "It is probable that the men of the future will overcome our shortcomings and build out of our thoughts and acts a finer mental and social structure—one that is in better keeping with Nature's heavy investment in the locally dominant human race." This is an aspiration that is surely good mental hygiene.

Fun For The Not-So-Young. By SID G. HEDGES. 142 pages. Cloth. Philosophical Library. New York. 1958. Price $3.75.

This British book is rather inadequate in the provision of useful clues to recreation for the elderly. However, off hand, this reviewer knows of no better book in this difficult field. Recreation department personnel and those connected with "Golden Age" Clubs would do well, therefore, to have this one handy.

Enemies and Friends. By W. H. PROSSER. 247 pages. Cloth. Little, Brown. Boston. 1958. Price $3.75.

A neurotic girl with two previous affairs marries an famous old man. After some years of seclusion, she becomes the mistress of a younger man, a painter. Despite portentious phrases and stylized verbiage, the author misunderstands a complex masochistic relationship, as a father-daughter pattern. Sex is treated in the most frigid fashion, and the predominant mood is that of despair. A good example of the author's attitude is a thought attributed to the lover-to-be, the painter. Thinking of his wife, "He wondered once more if it was not better for the artist—and that was to say any nonpersonal human being—to be homosexual: to be Proust, to be Gide, Michelangelo. . ."

Mark Twain. EDMUND FULLER, editor. 382 pages. Paper. Dell. New York. 1958. Price 50 cents.

Mark Twain is almost as useful as Shakespeare for the illustration of psychological material. An acquaintance with his works should be valuable to any student of psychology. This collection, however, was chosen for entertainment; it does not include the more valuable psychological work; and its chief interest to the psychiatrist would be in the examples it gives of the author's sadistic and cynical view of the American man and the American scene.

The Pearl Bastard. By LILLIAN HALE. 137 pages. Cloth. Braziller. New York. 1959. Price $3.00.

The Pearl Bastard is a briefly-told story of tragedy, reported by its young victim in a narrative style that appears to be a cross between stream-of-consciousness writing and what a client tells a social worker. This book has been praised highly by some critics, but the psychologically sophisticated reader is likely to find it all too skeletonized and with no clear picture of its motivation.

The Politics of Despair. By HADLEY CANTRIL. 265 pages. Cloth. Basic Books. New York. 1958. Price $5.00.

A psychologist attempts to explain the Communist "protest vote" in France and Italy. The book seems naïve to the psychiatrist because it centers around sociological problems, omitting discussion of underlying unconscious factors, which are merely hinted at. The reviewer thinks the author could have learned something from a contributor to a previous book he edited: *Tensions That Cause Wars.* Here, Dr. John Rickman, editor of the British *Journal of Medical Psychology,* stated: "Thus those who abject themselves before dictators do not know the reason why they must do so, any more than those that must run dangers and get

hurt realize the deeper motives for their actions; in the former case however they may experience an excited pleasure in their submissiveness. Masochism (the condition in which there is pleasure from the experience of pain) is not confined to the enjoyment of physical pain. The most common manifestation of masochism is satisfaction in enduring humiliation."

Clotilde. By CECIL SAINT LAURENT. 503 pages. Cloth. Morrow. New York. 1959. Price $4.95.

Once more, here is a book in which a topic that the reviewer considers interesting is butchered by bad writing and lack of understanding. The time and place are France during World War II; the topic is the resistance movement. The book, the reviewer thinks, is a complete mistake.

The Sacred Mushroom. Key to the Door of Eternity. By ANDRIJA PUHARICH. 262 pages. Cloth. Doubleday. New York. 1959. Price $4.50.

The Sacred Mushroom is the report of an experience and experimentation by a medical man who maintains a laboratory for the investigation of ESP phenomena; and both the student of ESP and persons interested in drug-induced hallucinations may have an interest in this book. Puharich reports on a device which he finds greatly increases the incidence of telepathic manifestations. He also discusses at great length the production of Old Kingdom Egyptian heiroglyphics and of utterances in ancient Egyptian by an individual in a trance. The author believes that he has ruled out possibility of fraud and that "disincarnate intelligence" was responsible. He admits the alternative possibility of telepathy or clairvoyance, however.

The Honey-pod Tree. The Life Story of Thomas Calhoun Walker. 320 pages. Cloth. John Day. New York. 1958. Price $4.50.

This book is prefaced by a publisher's note to the effect that the late Florence L. Lattimore, an investigator and lecturer of the Russell Sage Foundation, persuaded Mr. Walker to write down the story of his life. As a result we have a simple and unassuming account of the struggle of one of America's great Negro leaders. Born in slavery, Thomas Calhoun Walker lived to become, in the 1930's, administrator and consultant in Negro affairs for the emergency relief administration in Virginia. Later he returned to the practice of law and free-lancing for his people. With a keen insight into character, Mr. Walker wrote on various problems which concern the South, including the now timely one of integration. The title refers to the great tree in Gloucester, Va., which guarded the dreaded slave block, and from which many of the author's relatives were sold.

Among The Mormons. WILLIAM MULDER and A. RUSSELL MORTENSEN, editors. 482 pages and index. Cloth. Knopf. New York. 1958. Price $6.75.

Among the Mormons is a collection of contemporary pictures of Mormon society from the foundation of the sect to the present day. It is edited by recognized authorities and includes material both from members of the church and from unsympathetic "Gentiles." The Mormon movement has economic, sociological and psychological aspects in addition to the religious. The reader interested in human dynamics can find much information and considerable entertainment in this book.

Makers of Mathematics. By ALFRED HOOPER. 402 pages including index. Paper. Random House. New York. 1948. Price 95 cents.

Makers of Mathematics is a collection of biographical notes on the great mathematicians from ancient Egypt through the nineteenth century. It conveys, besides, clear ideas of what contributions each made to mathematical science; parts of the book, in fact, might be used as an introductory text. At 95 cents, this neat paperbound edition would be valuable for general reading or reference in any general scientific library or in the library of any science student.

Isaac Newton's Papers and Letters on Natural Philosophy and Related Documents: Containing Newton's contributions to the Philosophical Transactions of the Royal Society, his letters to Bentley and the "Boyle Lectures" related to them, the first published biography of Newton, Halley's publications about Newton's "Principia," etc. Editing and general introduction by I. B. COHEN, assisted by R. E. SCHOFIELD. Explanatory prefaces by MARIE BOAS, CHARLES COULSTON GILLISPIE, THOMAS S. KUHN, and PERRY MILLER. xiii and 501 pages with illustrations and index. Cloth. Harvard. Cambridge, Mass. 1958. Price $12.50.

The present book makes available in facsimile, from original sources, the interstitial material appearing in the *Isaaci Newtoni Opera quae exstant Omnia* (1779-1785) of Samuel Horsley, together with some related Newtonia as indicated in the present volume's subtitle. It is implied that together with the *Principia* and *Opticks*, which are easily obtained, this volume makes it possible to have all of the early printed productions of Newton on natural philosophy in a modern library. Some limitations attach to this project, in that (1) an arbitrary choice as to what constitutes natural philosophy seems to have been necessary, since when Newton wrote about even such matters as Biblical subjects, he still employed the methods and reasoning of a mathematician; and (2) there is possibly

a greater need to make practically inaccessible manuscript material available than to reproduce early printed material, which is merely very difficult and expensive to come by.

It would, however, be ungrateful to allow such minor and technical objections to interfere with one's enjoyment of the volume at hand, for there is enough in it to stimulate reflection and exciting conjecture through a good many evenings; and the prefaces contribute greatly. In a very real sense it is true that what one will get out of this Newton miscellany depends upon how well-stored a mind he brings to the book. Perry Miller's preface "Bentley and Newton," for example, moves along engagingly and properly emphasizes that Bentley recognized in the *Principia* a means for "proving" the existence of God. However, one would like to sit down before a fire with Miller to dig out of him exactly what he means by "Bentley . . . gave believers the assurance . . . that the Newtonian physics . . . was now the chief support of faith." It may be questioned whether Bentley should be credited with any particular astuteness in this direction when we recall that Newton's own *De Mundi Systemata,* although published after Bentley started work on his *A Confutation of Atheism from the Origin and Frame of the World,* is in fact only a popularization of the third book of the *Principia.* The close identification of Newton himself with matters theological was not lost upon his contemporaries and immediate successors. Thus David Brewster (*Life of Newton,* 1855, 2:313) observed, "If Sir Isaac Newton had not been distinguished as a mathematician and a natural philosopher, he would have enjoyed a high reputation as a theologian."

It has been difficult for the present reviewer to put down *Isaac Newton's Papers and Letters on Natural Philosophy,* difficult to avoid looking again into old William Whewell to see what *he* had to say about matters, difficult to avoid reaching up for the recent reprints of Abraham Cowley's misty poetry—the same Abraham Cowley whose death was one of those contributing to the nine Royal Society vacancies (one of which Newton filled) left after the plague in 1665-1666—and very difficuult, indeed, to terminate the present, incomplete review.

Murder and Its Motives. By F. Tennyson Jesse. 222 pages including index. Cloth. British Book Center. New York. 1958. Price $3.50.

The author's classification of murder motives is on the superficial level: for gain, for revenge, for elimination, for jealousy, for lust of killing and from conviction. She does not go into unconscious motivations or into psychodynamics. She does, however, display a good deal of (possibly unconscious) insight. Her murder for the lust of killing (of which Neill Cream affords the example), and her murders from conviction (Orsini's murders in an attempt to assassinate Napoleon III) should be of consider-

able interest to psychiatrists. Several of the other murderers, William Palmer and Constance Kent for examples, also present material of more than a little value to the student of mental abnormality. Miss Jesse's book is a re-issue of a classic in the field of crime reporting; and it would be of value in any social science library.

The Lamps Went Out in Europe. By LUDWIG REINERS. 302 pages. Cloth. Pantheon. New York. 1955. Price $5.00.

This book is an examination of the actions (or failures to take action) of heads of major European governments, foreign ministers, courtiers, and military men, in the period before and during World War I. It is esentially a history, but there are many interesting psychological pictures of the leading personages of the period. The volume deals with dozens of personalities especially the makers of foreign policy, and much of the book is focused on the Kaiser. As fair as the author has attempted to be, he cannot conceal his interest in the German conduct of the war or in Germany's "mistakes." In a chapter on war guilt, he blames Russia and France for causing the war. He has supreme admiration for the German soldier, in whom he sees superhuman fighting qualities compared with those of other nations.

A Short History of Psychotherapy in Theory and Practice. By NIGEL WALKER. 185 pages including index. Paper. Noonday. New York. 1959. Price $1.45.

Walker's short history of psychotherapy covers the period dominated by Freud and the divergent schools that are related to Freud, and, in addition, covers Pavlov's theory and the practice derived from it. The history is confined pretty strictly to the last 60 or 70 years, but the book gives a useful collection of short descriptions of the various psychotherapeutic schools. It is written from the British point of view; but it covers American developments adequately with the exception of individual psychotherapeutic treatment of the psychoses. It is as objective as could reasonably be expected. Throughout the book the author refers to the psychiatric patient as feminine. He does not explain why. The reviewer finds this highly irritating; but it, of course, hardly affects the value of the work.

Culture and Personality. By S. KIRSON WEINBERG. 58 pages. Paper. Public Affairs Press. Washington. 1958. Price $1.00.

In this brief booklet, the author undertakes an examination of the contributions of anthropology, sociology, psychoanalysis and psychology to the study and conceptualization of the nature of the relation between culture and personality. While all four disciplines, he stresses, are gen-

erally concerned with behavior, whether of the individuual or the group, each has had, of course, a distinctive conceptual framework, or bias, that has greatly determined methodology and conclusions. But as each discipline became more alert to developments in the others, says the author, a rich cross-fertilization began. In particular, the anthropologist began to utilize personality tests devised by the psychologist, while the psychoanalyst stressed the importance of motivation, and the importance of childhood training practices. In the meantime the psychologist emphasized the role of social factors in shaping individual behavior. Today all disciplines provide the concepts and methods that permit a more precise picture of the interrelations between individual and culture. While very compact, the author's summary should provide a useful perspective for those interested in the broader aspects of social behavior.

Everyday Life in Egypt. By PIERRE MONTET. 365 pages including index. Cloth. St. Martin's Press. New York. 1958. Price $8.00.

Montet re-creates in this volume the daily life, from birth to tomb, of both great and small in the glittering era of Egyptian power under Ramesses the Great and his immediate successors of the New Kingdom. There is an enormous amount of material here for contemplation by the social scientist and psychologist. The ancient Egyptian has a strong resemblance to modern man but also has a strange collection of rites and superstitions.

The psychiatrist will be particularly interested in the very much too-brief notes on the interpretation of dreams. "Sometimes," says Montet, "the interpreter is content simply to make a pun." The Egyptian words for "donkey" and "great" are homonyms, and to dream of a donkey is to dream of greatness. The words for "harp" and "bad" are very nearly homonyms; and to dream of a harp, is, therefore, bad. One may marvel at the parallel with modern dream interpretation or may wonder if—through Kabbala—Freud's interpretive principles were not derived from these very ancient practices. (It may be remarked that the Egyptian hieroglyphics—and perhaps all primitive writings—appear originally to have been based on puns. "Son" and "goose" are homonyms, and the title of the king, "son of the sun," is represented by the hieroglyph for "goose," coupled with the hieroglyph for "sun.")

The Origin of Civilized Societies. By RUSHTON COULBORN. 200 pages including index. Cloth. Princeton University Press. Princeton, N. J. 1959. Price $4.00.

To understand where we are, where we are going, and what, if anything, we can do about it, we need to know where we have been and why we have been there.

In *The Origin of Civilized Societies* a historian and archeologist presents his view of how man came to organize the first examples of what we consider civilization. He finds the drying up of the climate as the last great ice cap melted forced man to leave areas where he had long been a farmer and seek territories with more plentiful water—in most cases river valleys, in one, a tropical rain forest. He thinks that—with this enforced move and making it possible—there was an upsurge of religion, the worship of a water god. This is a controversial book. The footnote to the author's first page refers to the "egregious error" of a fellow-investigator, and there are other similar comments. The social or psychological scientist may enjoy the disputes.

An American Tragedy. By THEODORE DREISER. 863 pages. Paper. Dell. New York. 1959. Price 95 cents.

The reviewer presumes that most older readers of this journal are familiar with Theodore Dreiser's *An American Tragedy*. For the benefit of the younger, it could be described briefly as a long novel based on the actual incidents of a sensational crime and its punishment, and reflecting the original case very closely. It is an important document, socially and psychologically, as well as being a literary landmark. It is naturally no psychoanalysis; but it is a faithful portrait of a murderer and his apparent motivation. The reviewer thinks it should be available for collateral reading or study wherever psychiatrists or members of the associated disciplines are trained. At 95 cents, any hospital or school of nursing library should be able to afford it.

The French Faust. By MATHURIN DONDO. 225 pages. Cloth. Philosophical Library. New York. 1956. Price $3.75.

Dondo writes an interesting, purely descriptive, delineation of the life of Henri de Saint-Simon—French officer fighting for the American Revolution, later land-speculator, spendthrift, unsuccessful manufacturer, finally social philosopher and creator of a system which is considered a precursor of the socialistic schools. There are obvious parallels between his ideas and the paranoid situations he constantly created in his life; these are not worked out in the book. Only one trait is constantly stressed (though also not explained): Saint-Simon's pathologic bragging and megalomania.

Stochastic Models for Learning. By ROBERT R. BUSH and FREDERICK MOSTELLER. 365 pages. Cloth. Wiley. New York. 1955. Price $9.00.

Many psychologists have looked awry at the mathematical aspirations of colleagues who have hoped to bring into psychology the clarity and

economy of description which characterize the formal theoretical models of the physical scientist. In psychology, only in the area of learning theory has any significant success been attained in the formulation of such theoretical mathematical statements, and this largely through the monumental labors of Hull and his collaborators. But recent years have witnessed a growing dissatisfaction with the Hullian structure because of its premature comprehensiveness, its vagueness and looseness of description, and its deductive inflexibility. The present work is the result of a search for a more adequate model to describe the learning process; its direction is toward greater reliance upon mathematical models. While at first glance the mathematical formulations are formidable, "sufficient" elementary exposition is provided for the mathematically naïve or "rusty" reader.

The authors believe that "any systematic change in behavior [is] learning whether or not the change is adaptive [or] desirable." Furthermore, "behavior is intrinsically probabilistic" and thus may best be described by statements of the occurrence of certain response classes, and of the shift of probabilities from one class to another. The shift of such probabilities is always the function of an "outcome" of a response. This "outcome" may be a reinforcement, a change in environmental stimulation or proprioceptive stimulation. In defining an "outcome," the authors do not commit themselves to any particular "psychological theory" of learning, e.g. contiguity, or need-reduction, for they feel that their model is a general one which is capable of describing any of the current special theories through derivation. Their model is ahistorical in that no reference need be made to previous events in the organism's history for predictive purposes; the necessary information is contained in the statement of the response class probability before the operation of an "outcome." Of course, the organism's history will enter into the determination of the current response probability. In the first part of the book, these views are given formal and explicit statement in the development of the mathematical model. In the second part, the elements of the model are given behavioral referents, i.e. identified with organismic responses and environmental events; and the model is then in a position for use in the experimental arena. Specific applications of the model are made to actual situations and to reported experimental data. The complex problem of parametric estimation is amply discussed and illustrated.

The work is remarkably lucid and precise, with painstaking attention given to the exposition of troublesome mathematical manipulations. In the reviewer's opinion, the authors have contributed one of the most significant theoretical formulations in learning theory since the appearance of Hull's *Principles of Behavior.*

The Sanity Inspectors. By FRIEDRICH DEICH. 275 pages. Cloth. Rinehart. New York. 1957. Price $3.75.

Deich's book is one of the very few novels coming out of post-Hitlerian Germany, and admitting guilt: "I can never forgive myself that I have done nothing to oppose the inhuman cruelities of this authoritarian regime." These words are put into the mouth of the hero, a psychiatrist sacrificing his life for a friend, a Protestant minister. Otherwise, the book represents a conglomeration of irony at everything: religion, psychiatry, bureacracy, human stupidity, the concept of normality. ("A normal man is but a harmless imbecile.") Unfortunately, the hero is a mixture of a severe psychic masochist, a cynic, and a person with some superficial smattering of unconscious mechanisms. This, the reviewer thinks, gives the erroneous impression that, without these prerequisites, objections to authoritarian regimes are not feasible.

Bedlam. By ANDRÉ SOUBIRAN. 314 pages. Cloth. Putnam. New York. 1957. Price $3.95.

A book of cheap sensationalism is written by a French physician. A young advertising executive has become involved in some crime, never clearly stated, and cannot divulge his innocence without creating a scandal, the nature of which is also not stated. He decides to be silent, simulating a "psychiatric case." This vehicle serves as technique to permit the author to describe an antiquated French mental hospital for the criminally insane and 29 of its inmates. Compared with such institutions in the United States, the description is totally outdated. The book is thus calculated to exploit the sensationalism connected with "insanity" in laymen's minds, and is a rather regrettable performance.

Mental Subnormality. By R. L. MASLAND, S. B. SARASON, and TH. GLADWIN. 400 pages. Cloth. Basic Books. New York. 1958. Price $6.75.

Regrettably, this is a weak book on an important topic. The authors do little more than collect the vast literature from different viewpoints, without contributing anything new. A serious objection is the incomplete treatment of one of the most important factors, the problem of pseudofeeblemindedness. The authors are not informed of some recent work on this subject. The reviewer believes that these pseudocases are more frequently encountered than real mental subnormality.

Living With Your Heart in Health and Disease. By HENRY C. CROSSFIELD, M.D. 194 pages, including eight drawings and index. Cloth. Twayne Publishers. New York. 1957. Price $3.00.

This book, written for the layman, is another which the expert or specialist would not like to see in the hands of his patients. Not that it is technically inaccurate or is not up to date in data of research or

drugs on the market which are mentioned generously, but the type and manner of information are objectionable. For example: "Saline purges lower the potassium level but improve the circulation in the abdomen by drawing off a large amount of fluids through the colon. [A footnote says, "Magnesium in the laxative salts is beneficial, and its use helps correct the deficiency following consumption of excessive amounts of alcohol."] Purges, at intervals, do make people feel better, make them more tolerant to exercise and to excitement and decrease the likelihood of irregular heart action..." And later after discussion of "VEM and VIM and pherentasin"..."and its exact significance has not been determined," the author takes up the causes of hypertension: "recently a new idea was suggested by the observation that all the drugs effective in the treatment of hypertension have the ability to 'bind' trace metals. ...Large quantities of cadmium have been found in the kidneys of adults..." One might comment that it is not fair to take such sentences from their context; but the point is that public adult education is one thing, and giving undigestible, still debatable and possibly harmful, details, nicely blended into a pie for potential psychoneurotics (who will avidly assimilate books for the layman) is another.

Aspects of Human Equality. Fifteenth Symposium of the Conference on Science, Philosophy and Religion. LYMAN BRYSON, CLARENCE H. FAUST, LOUIS FINKELSTEIN, and R. M. MACIVER, editors. viii and 431 pages. Cloth. Harper. New York. 1956. Price $5.00.

Edited by writers and thinkers in the fields of philosophy, education, theology and social science, *Aspects of Human Equality* is a volume based on a symposium held at Columbia University in August and September, 1955. This book is the joint work of some 19 intellectual leaders and scholars.

Throughout the volume, the thesis is upheld that all men are philosophers enough to share a fundamental conviction that truth is opposed only by errors and half-truths, and good, only by evils and expedient compromises. The authors of the symposium articles underscore the view that philosophy in the sense of ordered knowledge, and philosophy in the sense of moral purpose, are both needed in our times. Also, it is held that the philosophy of equality recognizes the existence of inequalities and promotes differences. Again, the sound view is presented that liberty is not achieved by revolution but by tradition and gradual change; it depends on virtue and wisdom.

Aspects of Human Equality is a major contribution toward the knowledge and understanding between men and the nations they represent, and toward the psychological formulation of a sound—and even practical—philosophy of equality.

Philosophy and Analysis. MARGARET MACDONALD, editor. 296 pages. Cloth. Philosophical Library. New York. 1955. Price $7.50.

The editor of the present work has performed a valuable service in making available this collection of papers culled from the first 13 volumes of the philosophical journal *Analysis*. Published first in 1933, *Analysis* drew upon the efforts of a small but fervent group of young philosophers which stood as the *avant-garde* in the philosophy, which has become known as "logical postivism," "logical empiricism," or as one wit has put it facetiously, "logical negativism." The predominant influence on this adventuresome band derived from Russell and Wittgenstein.

The papers included in this collection as illustrative of the growth of this movement cover a wide range of philosophical problems, and represent the viewpoints of a number of prominent philosophers. Typical of the problems analyzed are those relating to: the problem of truth, the meaning of language, probability, and natural laws.

New York Establishes A State University. By OLIVER CROMWELL CARMICHAEL, JR. 414 pages including index. Cloth. Vanderbilt University Press. Nashville. 1955. Price $5.75.

This book presents and analyzes in detail New York State's executive, legislative and educational efforts toward organization of higher education during Dewey's second term as governor. The aim was to create a state university, and was finally accomplished after much strife, in 1949. The book is of great value to people interested in political and educational as well as administrative problems.

H. L. Mencken. By CHARLES ANGOFF. 236 pages. Cloth. Yoseloff. New York. 1956. Price $3.95.

Mencken's assistant on *The American Mercury* reproduces personal conversations with the satirist, with the aim of George Moore's aphorism, "Biographies should be a man's conversation, not his deeds." He succeeds in painting the picture of a boisterous, bizarre, partly irresponsible man, who—at times—was capable of brilliant, satirical aphorisms. Mencken's influence from 1924 to 1929 was enormous; he influenced a whole generation of college students and newspapermen. The irony was that Mencken —who fought prejudice and provincialism—was riddled with open prejudices himself. For instances, he hated democracy, defended slavery, attacked on principle every American president, and was half-anti-Semitic (he lost his best friend, Phil Goodman, because of his half-acceptance of Hitlerism). The book is worth reading, providing that the reader understands that many statements of Mencken's cannot be taken verbatim. The author knows that: "He enjoyed being an intellectual clown, perhaps also something of a mountebank."

The Psychology of Invention in the Mathematical Field. By JACQUES HADAMARD. 145 pages. Cloth. Dover. New York. 1954. Price $1.25.

This is an excellent and valuable presentation of unconscious factors influencing and producing original ideas. Although the author exemplifies with the science of mathematics, the deduction is applicable to every science. The decisive influence of unconscious factors is constantly stressed. The only objection to the book is that it does not go far enough. The unconscious is not a unit, and the inner tug of war among its "inner departments" is not included.

Christian Life and the Unconscious. By ERNEST WHITE, M.D. 190 pages. Cloth. Harper. New York. 1955. Price $3.50.

The author's premise in this work is that religion and psychiatry go hand in hand. The book is a meditation upon the main aspects of Christian life and the part played by the unconscious in relation to them. The author, in explaining the unconscious, does not argue with the Freudian concept. But he appears to use only those parts of that concept that he feels are consistent with the teachings of Christ.

Dr. White maintains that Christianity does not set out to crush our instincts but to develop and direct them to the highest aims. When Christ dwells in the heart, a new motive, a new goal is given all the forces in the mind so that the whole direction of life and conduct undergoes alteration.

Ministers and psychiatrists will find in this medical-religious work, a forward step in the co-operation of religion and psychiatry toward the happiness of the individual and of society as a whole.

The Writings of Martin Buber. By WILL HERBERG. 324 pages. Cloth. Meridian Books. New York. 1956. Price $1.35.

The writings of the Jewish religious philosopher are excerpted and edited with an introduction by Will Herberg. Unfortunately, both the introduction and the selected writings are comprehensible only to specialists with philosophical training.

Hiroshima Diary. By MICHIHIKO HACHIYA, M.D. Translated and edited by WARNER WELLS, M.D. 233 pages. Cloth. University of North Carolina Press. Chapel Hill. 1955. Price $3.50.

The author, director of an important hospital in Hiroshima, started a diary on August 6, 1945 (the day Hiroshima was hit by the atom bomb) and continued it until September 30. It is an interesting, and quite unemotional, report by a medical man. Medically, the most interesting part is the author's attempt to piece together, by trial and error, the results of radiation. The intestinal symptoms were first suspected to be symptoms of dysentery. Only gradually, was the full extent of radiation effects understood.

Sole Survivor. By LOUIS FALSTEIN. 191 pages. Paper. Dell. New York. 1955. Price 25 cents.

A moving, excellently written, story tells of a survivor from a Nazi concentration camp who, after liberation, meets his extermination camp torturer in the New York subway. What happens next is fiction, good fiction, but the compassion is genuine. A worthwhile book.

Worldwide Communist Propaganda Activities. F. BOWEN EVANS, editor. 210 pages. Cloth. Macmillan. New York. 1955. Price $3.00.

A valuable and documented report on worldwide Communist propaganda is edited with skill by a specialist in the field. It is highly informative and should be widely read.

Intent to Kill. By MICHAEL BRYAN. 191 pages. Paper. Dell. New York. 1956. Price 25 cents.

This one concerns the goings-on, legitimate and otherwise, in and about a hospital in Montreal. It is an excellent suspense novel, with the characters well-drawn, and is worth an evening of anyone's time.

Structure of the Ego. By LOVELL LANGSTROTH. 145 pages. Cloth. Stanford University Press. 1955. Price $4.00.

Otto Rank's *Will Therapy* has always impressed this reviewer as a confused and unreadable book. It was, therefore, gratifying to him to find a confirmation in the present volume—which attempts to utilize Rank's later writings and relate Rank's theories to a "possible anatomic basis for the ego." Langstroth says: "From that point on [the break from Freud] Rank continued to call his work 'will psychology' and his expressions became more and more abstruse until at times it is very difficult to know just what he means to say." The reviewer feels that the best that can be said about this book by Rank's enthusiastic pupil is that it is as incomprehensible as his master's.

Hinduism. By SWAMI NIKHILANANDA. 196 pages. Cloth. Harper. New York. 1958. Price $4.00.

Swami Nikhilananda's interpretation of Hinduism is a valuable book for anybody interested in comparative religion. To attempt to approximate: Hinduism might be described as monotheism with polytheistic manifestations. That is, the numerous and sometimes grotesque gods of India are aspects of "the conditioned Brahman." The conditioned Brahman itself is a manifestation of the unconditioned or pure being—"the negation of all attributes and religions." This latter concept has had much influence, not only on such outgrowths of Hinduism as Buddhism, but on western thought as well. A more general understanding of the religion depicted in this book would improve international and interpersonal relations.

Introductory Psychology. By ROBERT S. HARPER. 389 pages. Cloth. Allyn and Bacon. Boston. 1958. Price $5.75.

Robert S. Harper, associate professor of psychology at Knox College (Galesburg, Ill.), has written a fine text that will not only give a student a good basic knowledge of what psychology is but should develop an understanding and appreciation of the field. The book includes supplementary readings, selected from articles and books, to amplify some of the concepts discussed. These introduce the student to primary sources and give him a feeling for psychological research and experimentation. The text covers motivation, perception, learning and personality. The book's numerous illustrations make the material attractive and easy to comprehend.

The Night of the Good Children. By MARJORIE CARLETON. 192 pages. Cloth. Morrow. New York. 1957. Price $2.95.

To say that this is a good mystery novel with an eerie atmosphere and characters both believable and appealing would be quite true. And it is more than that, for Mrs. Carleton has given a picture of some brave and good teen-agers, a refreshing subject today. As the author says, "They are taller and stronger, and perhaps braver than their parents."

The book should be of interest as a character novel as well as a first-class suspense yarn.

Murder Takes a Wife. By JAMES A. HOWARD. 192 pages. Cloth. Dutton. New York. 1958. Price $2.95.

The author apparently attempted to make this a heart-stopper horror story with a surprise ending—and some autobiographical reflections of a psychopathic killer thrown in. The tough professional killer and his lady victims fail to be convincing as real people; and in the reviewer's opinion, the whole sordid mess, instead of being spine-chilling, succeeds only in being somewhat sickening.

Watch Your Language. By THEODORE M. BERNSTEIN. 276 pages including index. Cloth. Channel Press. New York. 1958. Price $3.95.

Watch Your Language is a useful discussion of what to write and what not to write, as illustrated by the *New York Times*. Compiled from the advice of an assistant managing editor to *Times* reporters and copy editors, this is an excellent handbook. It cites examples of common mistakes and examples of unusually good writing and editing. This book is of primary use to newspaper people, but any writer or editor can profit by reading it, and be amused at the same time. Incidentally, this is an excellent book for anybody who cannot understand why newspapers "make so many mistakes" and print such "stupid headlines." It shows how these things come about and why some of them are unavoidable.

The World of Henry Orient. By NORA JOHNSON. 214 pages. Cloth. Atlantic-Little, Brown. Boston. 1958. Price $3.75.

The World of Henry Orient is a tale of two 13-year-old eighth-graders from New York families that are better endowed with money than sense. The heroine is a little lady whose IQ falls just short of the genius level, who is an accomplished pianist and a brilliant student and who leaves her private school every afternoon for a session with a psychoanalyst. The tale is related by the young genius' girlfriend. It is told in part, with the emotions, and in the words, of a schoolgirl; but the author's own experience and maturity take over now and then to picture childhood, not as it is, but as a highly sophisticated adult remembers it. Aside from the rather slender plot, which it would be unfair to the reader to discuss, the roles of the psychoanalysis and the psychoanalyst are of interest.

Live and Let Live. By EUSTACE CHESSER. 126 pages. Cloth. Philosophical Library. New York. 1958. Price $4.75.

Live and Let Live is a brief commentary on The Report of the Committee on Homosexual Offences and Prostitution, made public in Great Britain some time ago. It has interest for sociologists and students of psychological abnormality, in that it is a well-written plea for tolerance. The author appears not to understand the psychodynamics of homosexuality, and he seems to be naïve about fellatio. This book is of minor importance to the American reader but of considerable importance to the British reader. The subject is of such restricted interest that it is difficult to see why this book was ever reprinted in this country.

Going Into The Past. By GORDON J. COPLEY. 192 pages including index. Paper. Penguin. Baltimore. 1958. Price 85 cents.

Going Into the Past is a fascinating little treatise that aims to introduce young people to a basic science, and is in the form of a guide. It covers the visible antiquities of Great Britain with particular attention to England. The reviewer suggests that a similar book about the United States, its pre-history and early history, would serve an admirable purpose.

The Perils of Prosperity. By WILLIAM E. LEUCHTENBURG. 313 pages including index. Cloth. University of Chicago Press. 1958. Price $3.50.

This book is a popular portrayal of an important sociological subject, the boom and bust years of the United States from 1920 to 1932. It is a sobering text and a very readable one.

Keep Listening. By FRANCES WARFIELD. 158 pages. Cloth. Viking. New York. 1957. Price $2.95.

An interesting book, mostly autobiographical, reports on medical help to a person hard of hearing.

Borneo People. By MALCOLM MACDONALD. 425 pages. Cloth. Knopf. New York. 1956. Price $6.50.

Borneo People purports to be a travel book with descriptions of the pagans of Sarawak as their British administrator saw them. It is, however, rather more than that. If it is not a full-dress study in social anthropology, it is an enlightened and rather objective report from the ethnological viewpoint. Mr. MacDonald shows the forces at work in the slow transformation of a primitive society to adapt it to the modern world. He discusses with sympathy the ancient cultures of the Ibans, Kayans and Melanaus, taking up the changes that contact with Europeans is bringing. It should be recorded that the author does not approve of all of them. He finds in general, however, that the Borneo pagans are intelligent, are capable, and have good prospects of eventually stabilizing their rapidly changing culture. Under its famous white rajahs, the Brookes, Sarawak made long strides toward modernity. Under intelligent British colonial administration, those creditably long strides appear to be lengthening.

How The Great Religions Began. By JOSEPH GAER. 257 pages including index. Paper. Signet. New York. 1956. Price 50 cents.

Joseph Gaer's small book is a reprint of a volume first published in 1929. It covers the religions of the Far East, Zoroastrianism, Judaism, Christianity and Mohammedanism. A person generally familiar with the subject could usefully use this volume as an outline and guide; but the author has been too selective for its use as a general introduction. For instance, in discussing Christianity, he suggests pretty plainly that the facts are just what he personally believes. The interest of the social scientist, however, is in what the devout followers of a religion themselves believe, not what a commentator thinks about it.

Witchcraft. By CHARLES WILLIAMS. 316 pages including index. Paper. Meridian Books. New York. 1959. Price $1.45.

This is a short summary of what is generally known on the subject of witchcraft. It is overcompressed, and the reviewer thinks the author is overcautious in drawing conclusions. He draws almost no conclusions, in fact, presenting his narrative and letting the reader judge for himself, which is not easy to do from such a bald and compressed account. Williams presents the medical or psychiatric aspects of witchcraft adequately and gives a sufficient chronological outline. There is an interesting sketch of the incident of Madame de Montespan and the black mass, a well-known instance of witchcraft of which details are difficult to find in print. Williams does take one firm stand; he believes the Spanish Inquisition was lenient, on the whole, with witches, as contrasted to its attitude toward heretics in general and to the attitude of other repressive authorities toward the witches themselves. This book is a useful outline, but too condensed for an introduction.

The Captive and the Free. By JOYCE CARY. 369 pages. Cloth. Harper. New York. 1959. Price $5.00.

During the last three years of his life, Cary was preoccupied with this novel, which deals with faith-healing. His health deteriorated ("his hands were now so paralyzed that he could no longer even turn a page," states the editor), and the novel was not finished. Still, it is an interesting work, in which the author shows a certain understanding of masochistic motivations:

"Danger and suffering do have a fascination for people of Preedy's type [Preedy is the shady hero of the book], who are set apart from the ordinary common judgments of the world by all sorts of reasons. . ."

That Distant Afternoon. By ROY FULLER. 248 pages. Cloth. Macmillan. New York. 1959. Price $3.75.

The author attempts to reconstruct the life of an adolescent boy in an English preparatory school. Although he seems to have some occasional inkling of deeper psychic mechanisms ("habitual injured tone," "capable of misery," "tiny wrongs" etc.) the book is so poorly written that it is difficult to read.

The Snatch. By HAROLD R. DANIELS. 160 pages. Paper. Dell. New York. 1959. Price 25 cents.

A kidnaping is executed without plan by three men who quarrel after the deed, especially since they don't know what to do with the boy they have abducted, although the ransom has been paid. There is not the slightest attempt to explain the psychology of the criminotics.

Nerves Explained. By RICHARD ASHER, M.D., F.R.C.P. 157 pages. Cloth. Thomas. Springfield, Ill. 1958. Price $2.75.

This is a fascinating little book. It was written as "a straightforward guide to nervous illnesses" for British laymen, and fulfills its objectives remarkably well. This reviewer disagrees, at times almost violently, with a few of the author's statements—the author being no friend of psychoanalysis—but this is merely quibbling. For the audience for whom it was written, the book contains a wealth of practical explanations and stresses many sound mental health principles. Yet the reviewer is hard put to name an audience for whom it is appropriate in this country. The British vocabulary and terminology would be strange to American laymen. It seems likely, however, that psychiatrists, nursing school instructors and members of allied disciplines might find it worth reading, either for themselves or as containing material to help instruct others.

Professional Preparation in Health, Physical Education, and Recreation. By RAYMOND ALBERT SNYDER and HARRY ALEXANDER SCOTT. 421 pages. Cloth. McGraw-Hill. New York. 1954. Price $5.50.

This book is intended primarily as a text, and as such it fulfills its purpose. Outside usefulness, will, however, be limited. This is not because useful information is not present, but because it is submerged under detail.

St. Dingan's Bones. By JULIAN CALLENDER. 179 pages. Cloth. Vanguard. New York. 1958. Price $3.50.

This is a thoroughly delightful bit of Irish humor, set in a small village in western Ireland. The peace and beauty of the town are threatened when it becomes known that two precocious children have dug up what are assumed to be the bones of the patron saint of the village. There is much ribbing of things Irish, but it is all done in a manner offensive to no one. The author's insight into character is unusually good. It is altogether a refreshing book to come upon.

Take Off Your Mask. By LUDWIG EIDELBERG, M.D. 156 pages. Paper. Pyramid. New York. 1959. Price 35 cents.

Take Off Your Mask is a paperback reprint of Dr. Eidelberg's book describing psychoanalysis for the general reader. It has been remarked that it will mislead some such readers, while it is too simple for the psychiatrist. If it misleads, however, it does so in a direction which is not too detrimental to mental health. It necessarily oversimplifies, and in the reviewer's opinion it overdramatizes, but it does give a general idea to the uninformed of what psychoanalysis is about. It is extremely readable and this low-priced reprint can therefore be welcomed—if with some caution.

Call Down the Storm. By LEGETTE BLYTHE. 320 pages. Cloth. Holt. New York. 1958. Price $3.95.

This is a fascinating and unusual book about the South. The main portion of the story deals with a white doctor who, jilted by his sweetheart just after the Civil War, turns to an attractive quadroon, and brings up an illegitimate family. This section of the book is an entity in itself, tragic and moving, with excellent character portrayal. The final part shows the South today, with the descendants of the white girl who jilted the doctor and those of the doctor's octaroon family. It chiefly concerns the subject of integration in the schools. Obviously, the author feels, integration must and will come in time and "massive resistance to the Supreme Court's decision may be calling down a storm that would do our entire nation untold damage, and wreck the public school system in the South." This is a timely book and a good one.

Adolescence and the Conflict of Generations. By GERALD H. J. PEARSON. 181 pages. Cloth. Norton. New York. 1958. Price $3.95.

The author of *Emotional Disturbances of Children* has produced a pedestrian and popular volume on adolescence, without, the reviewer thinks, saying anything new, or even interesting, on the topic. His explanations of the problems are a rehash of the already known (leaning to the most conservative side in psychoanalysis).

Cohort Studies of Mental Disease in New York State, 1943-1949. By BENJAMIN MALZBERG, Ph.D. XIV and 113 pages. Paper. National Association for Mental Health. New York. 1958. Price $2.00.

Statistics are a dry mouthful to swallow, and there will be few who have the required type of mind to read this book and enjoy it the way one would a novel. Yet we all recognize that it is statistical analysis that must establish the results of research work. The figures in this book deal with the discharge and mortality rates, month by month, of admissions to the New York State mental hospitals. As the end of this particular study takes place just before the advent, at least in significant amounts, of the "tranquilizing" drugs, this reviewer will be very interested in a follow-up study.

The Natural Science of Stupidity. By PAUL TABORI. 288 pages including index. Cloth. Chilton Company. Philadelphia. 1959. Price $4.50.

Paul Tabori is a novelist, a biographer, and a historian who takes a smashing blow at human folly in this very readable and erudite book. The author quotes a favored insult of central Europe between the two world wars. " 'Tell me—does it hurt to be stupid'? Unfortunately, it doesn't. . . . Stupidity . . . seldom hurts the stupid. . . . And that is the tragedy of our world and the subject of this book." Cupidity, court ceremonial, aristocratic pretensions, red tape, legal asininities, hoaxes, wish-dreams, and the extravagancies of love are among the targets of this entertaining volume.

There are numerous diverting anecdotes. There is a note on Pope Sylvester, II who was a man of very great scientific and mathematical achievements, but who won the repute of being a magician instead. There is the swindle worked on the famous mathematician, Michael Chasles who paid 140,000 francs for forged letters of characters ranging from Isaac Newton to Mary Magdalene. There is a presumably true story of Ulrich von Lichtenstein whose chivalry outdid Don Quixote in idiocy. Tabori's book has no scientific pretensions but anybody concerned with the science of the human mind should find it interesting and full of illuminating instances of human foolishness.

CONTRIBUTORS TO THIS ISSUE

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Lake City. He had an organ scholarship at the Chicago Musical College in 1928, was organist at the United Artists Theater in Chicago in 1928 and 1929, and was a concert and theater organist and pianist in Sydney, Melbourne, Adelaide and Brisbane, Australia from 1929 to 1935. He was later a concert pianist, teacher and church organist in Salt Lake City. From 1942 to 1946 he was a combat intelligence officer with the United States Army Air Force. After discharge from military service, he attended the Juillard School of Music where he graduated with a diploma in piano major in 1948. He later made two transcontinental concert tours as piano soloist and accompanist with a trio. He has been a teacher of piano and theory in Veterans Administration hospitals for the Hospitalized Veterans Service of the Musicians Emergency Fund. Since 1944 he has been director of special projects of the Hospitalized Veterans Service.

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HELEN A. DeROSIS, M.D. Dr. DeRosis is in the private practice of psychoanalysis in New York City. She is a graduate of the New York University College of Medicine in 1953. Following an internship at Bellevue Hospital, New York City, she had psychiatric training at the New York State Psychiatric Institute and psychoanalytic training at the American Institute for Psychoanalysis, New York City. She has done clinical work at St. Vincent's Hospital and Roosevelt Hospital, New York City. She is a member of the American Psychiatric Association, the Association of Medical Group Psychoanalysts and other professional organizations.

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He has contributed previously to THE PSYCHIATRIC QUARTERLY.

WILLIAM C. JOHNSTON, M.D. Dr. Johnston was born in Canada and received his medical degree from the University of Toronto in 1925. For seven years before 1940, he was physician of the medium security prison at Walkill, N. Y. Since 1940 he has served in various grades at Matteawan State Hospital. During World War II, he was chief psychiatrist in a United States Navy Disciplinary Barracks and was returned to inactive duty with the rank of commander. He is a diplomate in psychiatry of the American Board of Psychiatry and Neurology. He is now an assistant director at Matteawan (N. Y.) State Hospital.

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NORMAN LAMBERT DAVIDSON. The Reverend Norman Lambert Davidson is at present a mental health worker for the Florida Board of Health. He lives in Quincy, Fla. For four years before going to Florida, he was a chaplain in the New York state hospital service, first at Pilgrim State Hospital, then at St. Lawrence. Born in Pennsylvania in 1893, Mr. Davidson is a graduate of Wesleyan (Conn.) University in 1917. He received his B.D. from Garrett Biblical Institute in 1921. He was in the armed forces during World War I.

Mr. Davidson received a master's degree in education from Temple University, Philadelphia, in 1948 and since that time has been engaged in pastoral counseling and mental hygiene work. He interned in clinical pastoral psychiatry at the state hospital, Marlboro, N. J., in 1948 and at Federal Detention Headquarters, New York City, in 1949. He is a graduate of the New York State chaplain course in psychiatry. He was a pastor in the Philadelphia Methodist Conference from 1921 to 1942, served as an army chaplain from 1942 to 1946 and was with the Veterans Administration in 1947. He has been adult adviser and pastor in the Panama Canal Zone and has held counseling, chaplaincy and group therapy positions in Pennsylvania and Iowa.

JACK L. WARD, M.D. Dr. Ward is a graduate of Union College, Schenectady, N. Y., in 1948. He received an M.A. in psychology from Temple University, Philadelphia, in 1949 and was graduated from Jefferson Medical College, Philadelphia in 1953. After a rotating internship, he had a psychiatric residency at St. Elizabeths Hospital, Washington, D.C., then was with the United States Public Health Service as chief of psychiatric services at the National Training School. While he was with the public health service he was also psychiatrist at the evening clinic of the Washington Institute of Mental Hygiene. He is now serving a psychiatric residency at the New Jersey Neuro-Psychiatric Institute in Princeton. He has been in private practice since 1955.

ZYGMUNT A. PIOTROWSKI, Ph.D. Dr. Piotrowski is clinical professor of psychology at the Jefferson Medical College of Philadelphia, where his chief duty is research. He is also research consultant of E. N. Hay and Associates in Philadelphia, lecturer at Temple University, and consultant for the Philadelphia Veterans Administration Regional Office. Born in Poznan, Poland, he obtained his Ph.D. at the University of Poznan. Postgraduate studies were pursued at the University of Paris and Columbia University. He was connected with the psychiatry department of the College of Physicians and Surgeons in New York and with the research department of the New Jersey Department of Institutions and Agencies before he went to the Jefferson Medical College.

Dr. Piotrowski has written extensively on the Rorschach inkblot method. His book, *Perceptanalysis,* is an extension and systematization of that method. He is an associate editor of THE PSYCHIATRIC QUARTERLY and SUPPLEMENT, in which he has published a number of his articles. A paper originally published in THE QUARTERLY in 1947 and revised in 1950 is now part of a Rorschach instruction booklet published by The State Hospitals Press. He is continuing his efforts at developing the sensitive Rorschach test as a diagnostic and prognostic aid in neurology and psychiatry.

BARRY BRICKLIN, M.A. Mr. Bricklin was born in 1933 in Philadelphia. He received his B.A. and M.A. degrees from Temple University. Both he and his wife, Patricia, are currently completing work toward their Ph.D. degrees in psychology at Temple. Mr. Bricklin has served as graduate assistant in the Temple University Psychological Clinic, and clinical psychologist at the Temple University Reading Clinic, and is now a staff psychologist in the department of psychiatry at the Jefferson Medical College of Philadelphia.

NEWS AND COMMENT

JAMES N. PALMER, M.D., ASSOCIATE EDITOR, DIES AT 47

James N. Palmer, M.D., New York City psychoanalyst and an associate editor of THE PSYCHIATRIC QUARTERLY and PSYCHIATRIC QUARTERLY SUPPLEMENT since 1941, died suddenly in his office in New York on December 2, 1958. He had been in poor health for some years.

Dr. Palmer was a veteran of the New York state hospital system. Born in Glens Falls, N. Y. in 1911, he was a graduate of New York University where he had a full scholarship, and he received his medical degree from McGill in 1937. Dr. Palmer's father had been a surgeon, but the son never practised surgery. After a year in general internship, he joined the staff of Utica (N. Y.) State Hospital; had a fellowship at the Austen Riggs Foundation and returned to Utica where he entered army service in 1942, serving until 1946. He was assistant chief and chief of neuropsychiatric services in hospitals in Australia, New Guinea and the Philippines.

He returned to Utica for a year, then went to New York for psychoanalytic training. He served as assistant chief of the mental hygiene clinic at the Bronx Veterans Administration Hospital, then entered private practice. Dr. Palmer became an associate editor of THE PSYCHIATRIC QUARTERLY and PSYCHIATRIC QUARTERLY SUPPLEMENT in 1941. He was an active member of the editorial board and engaged in other editing and writing.

More extended notes on his career, and an appreciation, will appear in the January 1959 number of THE PSYCHIATRIC QUARTERLY.

Dr. Palmer leaves his wife, the former Ann Scully, whom he married shortly after his service in the army.

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HARRY J. WORTHING, M.D., DIRECTOR OF PILGRIM, IS DEAD

Harry J. Worthing, M.D., director of Pilgrim (N.Y.) State Hospital, died on July 22, 1958 at the age of 70. Dr. Worthing had been with the New York State Department of Mental Hygiene for 45 years and had been director of Pilgrim since 1937.

Born in Norwood, N. Y., Dr. Worthing was a graduate of Syracuse University Medical School in 1913. He joined the staff of St. Lawrence (N. Y.) State Hospital in that year and remained with the department until his death, except for army service during the Mexican border trouble in 1916 and during the first World War, in which he was division psy-

chiatrist of the 27th Division. He returned to St. Lawrence, studied at the Psychiatric Institute, became first assistant physician at Harlem Valley (N. Y.) State Hospital, then was clinical director and first assistant at St. Lawrence. He had been superintendent at Willard (N.Y.) State Hospital for two years when he was named head of Pilgrim.

Dr. Worthing was active in shock therapy, psychotherapy and psychosurgery programs and was author or co-author of a number of scientific papers on these subjects.

MENTAL ILLNESS COST $3 BILLION A YEAR

Direct and indirect costs of mental illness in the United States amount to more than $3,000,000,000 a year, according to an estimate by Jack R. Ewalt, M.D., director of the Joint Commission on Mental Illness and Health. The commission represents more than 35 professional service agencies, and its report covering costs is being published under the title of *Economics of Mental Illness* by Dr. Rashi Fein. Dr. Fein's book is the second of 10 studies to be made during 1958 and 1959 for the commission.

KARL SPENCER LASHLEY, PSYCHOLOGIST, DIES AT 68

Karl Spencer Lashley, Ph.D., one of this century's outstanding figures in psychology, died of a heart attack in Poitiers, France, on August 7, 1958 at the age of 68. Dr. Lashley was a distinguished figure in the fields of physiological psychology, the mechanism of learning and the theory of psychological phenomena. He was instrumental in the movement which led to the deflation of overvalued theories which attributed different psychological processes to specific cortical areas. He is quoted as remarking once that he had destroyed all theories of behavior, including his own. Dr. Lashley's psychology was firmly based in biology, zoology and comparative anatomy.

Dr. Lashley was graduated in 1910 from the University of West Virginia, where his principal studies included embryology, histology and animal behavior. He obtained a teaching fellowship in bacteriology at the University of Pittsburgh where he received his M.S. in 1911. His Ph.D. was in zoology, obtained in 1914 at Johns Hopkins, where he studied psychology under both John B. Watson and Adolf Meyer. His interest in psychology dated from this time and his first publications in psychology were in 1914. Dr. Lashley's early activities included research work with Shepherd Ivory Franz of Saint Elizabeths Hospital, work with Watson on popular attitudes toward sex, neurological study of behavior, and teaching as full professor at the University of Minnesota. Dr. Lashley went to Harvard in 1935, where he was, first, professor of psychology

and, later, research professor of neuropsychology, a position which allowed him to become director of the Yerkes Laboratories for Primate Biology in Florida. He retired within the last few years as professor emeritus at Harvard and emeritus director of the Yerkes Laboratories. Lashley's work in demolishing premature physiological conceptions of learning, his own anatomical work, and his studies of learning, are considered of major importance in modern psychology. Dr Lashley was the recipient of numerous honorary degrees. He was president of the American Psychological Association in 1929. He was a member of the Society of Experimental Psychologists, the American Society of Zoologists, and the American Physiological Society, besides other professional organizations. Dr. Lashley had been seriously ill in 1954 but had appeared to be recovered. He undertook a trip to Alaska in 1957 and was on a trip to Europe when he died of heart disease.

Dr. Lashley leaves his wife, the former Claire Imré Schiller, whom he married in 1957. His first wife, ill for years, died in 1948.

S. H. FLOWERMAN, PSYCHOLOGIST, DIES AT 46

Dr. Samuel H. Flowerman, psychologist and psychotherapist, died in New York City on July 29, 1958 at the age of 46. Dr. Flowerman had just completed a term as president of the New York Society of Clinical Psychologists. He was formerly director of scientific research for the American Jewish Committee and was co-editor of the five-volume work, *Studies in Prejudice.*

NEW STATE SCHOOL TO ADD 1,000 BEDS

About a thousand new beds for infirm patients will be added to the state school facilities of New York by the institution which is to be constructed in West Seneca, according to announcement by Commissioner Paul H. Hoch, M.D., of the New York State Department of Mental Hygiene. Dr. Hoch points out that there are now waiting lists for admission to the state schools, and notes that the need for the new West Seneca building is acute.

MARIE STOPES, SEX EDUCATOR, DIES AT 78

Dr. Marie Carmichael Stopes, birth control advocate and author of the book, *Married Love,* died at her home in England on October 1, 1958 at the age of 78. Dr. Stopes was a biologist and paleobotanist. Her birth control efforts were the subject of a long controversy in both Great Britain and the United States. She was the mother of two children, one of whom (a son) survives her.

JOHN B. WATSON, BEHAVIORISM FOUNDER, DIES

John B. Watson, founder of the behaviorist school of psychology, died in New York on September 26, 1958 at the age of 80. Dr. Watson's theories, sometimes considered to be an adverse reaction to Freudianism, had much influence on both teaching and practice of psychology. His important books, *Behaviorism*, *Psychological Care of Infant and Child*, and *Psychology from the Standpoint of a Behaviorist*, were all published in the 1920's. Dr. Watson was professor of psychology at the Johns Hopkins University when he resigned to enter the advertising business. He retired as an officer of one of the large national advertising agencies in 1945.

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